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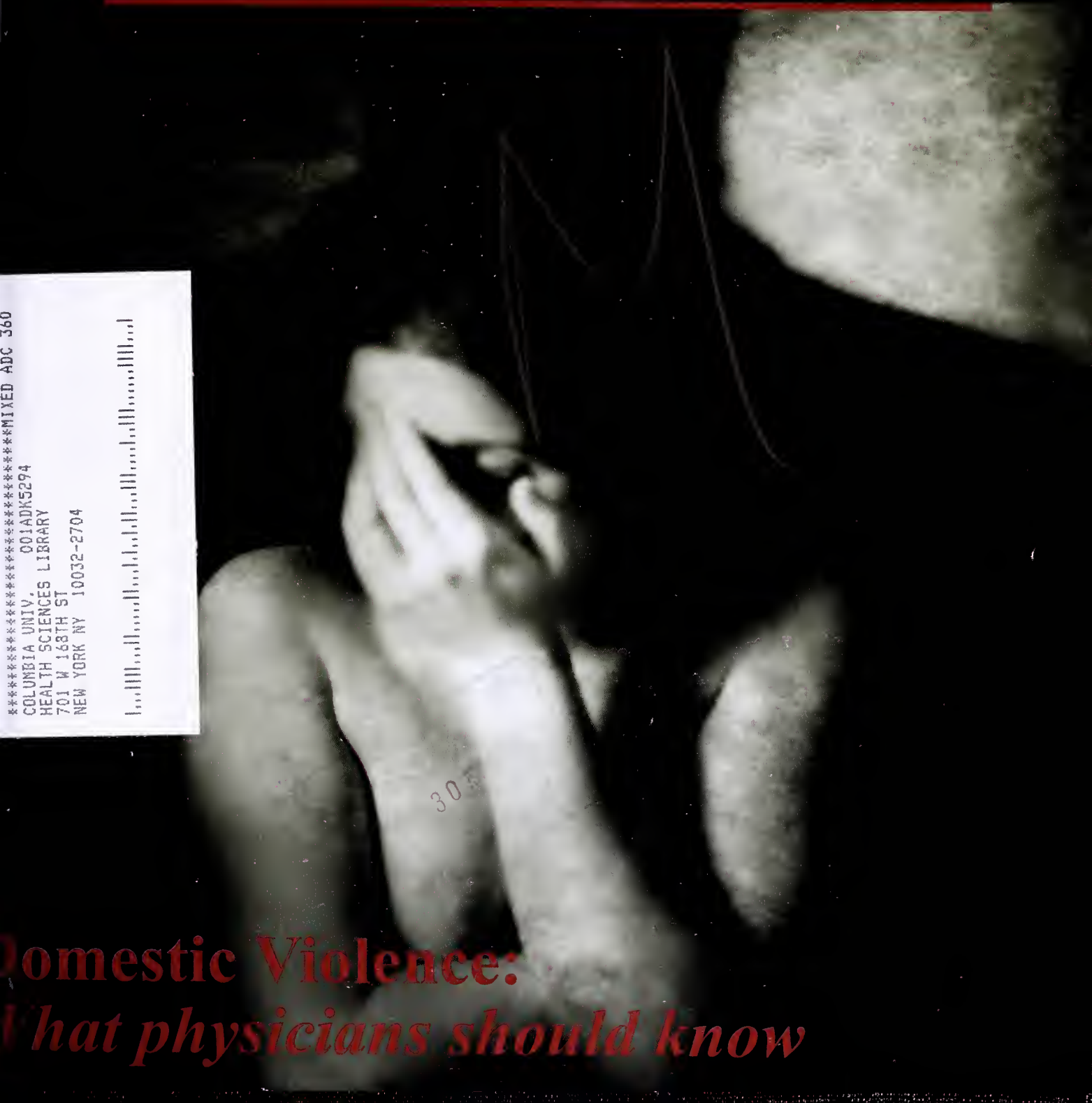
Volume 3 Number 1, Winter 1999

MASA REVIEW

Incorporating Alabama Medicine,
The Journal of the Medical Association of the State of Alabama



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Domestic Violence:
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MASA REVIEW

Incorporating **Alabama Medicine**,
The Journal of the Medical Association of the State of Alabama

Volume 3, Number 1 **Winter 1999**

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Editor William A. Curry, MD
Managing Editor Amanda Jones
Book Review Editor David W. Hodo, MD

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Stopping Violence

Read the headlines... terrorist bombings , ethnic cleansings, military coups, coed rapes, high school shootings, doctors murdered, etc., etc. And then the fine print (or no print at all)... wife beaten, children abused. One wonders when it will all end, what is its genesis, who is responsible, and who can do anything about it. And I ask, what is the role of organized medicine in fighting violence?

Violence outside our borders is something we will have little influence over as an association. It does, however, put things into perspective. When viewed globally, our society does not seem as violent, considering the horrors of the Holocaust, the mass killings in Cambodia, the massacres between ethnic African groups, the "purification" in Bosnia and Kosovo, the deep hatred between Palestinians and Israelis. This does not excuse the individual brutal acts that take place rather routinely in our country and our state. True, crime is down with murder being at its lowest rate since 1967, but that is no consolation to the victim of a senseless beating or the family of a murder victim.

Domestic violence, in particular, is still at epidemic proportions. Battering is the single most common cause of injury to women. One third of all women seeking care in emergency rooms are battered and one third of pregnant women are abused. Medical expenses from domestic violence total more than $5 billion annually. Another $5 billion is estimated for police and court costs, shelters and foster care, siek leave and loss of productivity. Thirty percent of homicides of women were at the hands of their husbands or boyfriends. Three million cases of child abuse occurred in 1997, a 200% increase in less than ten years. In Alabama, in 1997, there were 62,500 simple assaults, 40 percent of which were domestic assaults, and 24,650 other violent offenses (rapes, homicides, etc.), 18 percent of which were domestic. None of this surprises any of you who have worked the emergeney room.

Another rather recent development comes on the heels of the cold-blooded assassination of Barnett Slepian MD apparently because he performed abortions. A website has been created which posts the names of physicians who allegedly perform abortions, abortion clinic owners, and judges, including Supreme Court Justices. These names are listed as Working, Wounded, and Fatality. Information is given about these persons and their families. Their stated goal of this group is to publish the names of everyone "working in the baby slaughter business in the United States." It is nothing more than a hit list. What's to keep other doctors who are not abortionists off the list. As this is written, a $107 million verdict has been declared in Oregon against others who have targeted physicians. The appeal will be a true test of First Amendment rights. Neal Horsley, the originator of the website, declares he will keep it open.

Another interesting development at this writing and which will probably be decided by the time this is in print, is plaintiffs, mostly large cities which have high homicide rates, suing manufacturers of guns. This is a similar tactic to suing tobacco companies, with an important difference... guns do have some potential value in law enforcement and, theoretically, in self defense, whereas tobacco has no redeeming value. Atlanta mayor, Bill Campbell, says he just wants gun makers to make their products safer. That's a laudable goal, but gun accidents account for only a small portion of gun related injuries and deaths. It's the people who have the guns, their intent, and misuse that's the problem. Guns don't commit crimes. Somebody must pull the trigger.

Perhaps the overall crime rate is down because these are good economic times with the stock markets at record highs, unemployment at its lowest level in years, and interest rates and inflation at their lowest levels in decades. Another possible explanation is that there are more criminals in prisons than ever before. If there are large scale releases from prisons, due to overcrowding, and the economy weakens, as it surely will, there will be serious increases in violent crime.

Characters in Walker Percy's novels, set in Louisiana, lived in a constant "malaise," interrupted only by impending hurricanes, apparently the only thing they had to live

(continued on page 29)

— Joel C. Pittard, MD

Addressing Violence - How to Get Involved?

In his President's Message, Joel Pittard, MD, lays out before us the seriousness of the consequences from domestic violence. Allow me to go further to describe what your physician organizations are doing to address this public health issue which somehow or some way hits each and every one of us.

Your MASA, in addition to working with its Alliance, and the Alabama Coalition Against Domestic Violence (ACADV), is working also with state specialty societies to bring this issue before their memberships. Prior to the joint press conference on SAVE (Stop America's Violence Everywhere) Day in October, we met at an Alliance sponsored conference with representatives of family physicians, internal medicine, obstetrics/gynecology, pediatrics and emergency medicine to involve them in this statewide effort.

This is our plan:

- Compile rosters of existing, community-based initiatives. This will be ACADV groups in some areas, county Alliance projects in others, or independent community projects.

- Initiate physician education efforts through county and specialty society newsletters. The Alabama chapters of the American Academy of Family Practice and the American College of Emergency Physicians already have taken this ball and run with it. As Dr. Pittard mentioned, physicians are in a unique position to make a difference with early identification and intervention. You just need the tools and skills to do it and where to refer the victim once identified. One such tool is the Physician Reference Card which the Alliance had reproduced. The reference card provides you with tips on what to look for in a potential victim and questions to ask to confirm the problem.

- Encourage county and specialty societies to include speakers on domestic violence in their regular and annual meetings.

- Identify physicians who are interested and willing to work within local initiatives and put them to work.Identify other organizations with an interest in addressing domestic violence issues and work them into local and statewide initiatives. The Junior League and the Alabama Cooperative Extension Service are two which come immediately to mind.

- Assist local initiatives in developing a media relations plan to make sure community members know what's going on, how they can become involved and where to turn if they are victims of domestic violence.

- Continuously evaluate what we're doing and how we're doing it so that we can become more effective in our efforts.

As I mentioned, domestic violence affects each and every one of us. It crosses all socioeconomic lines. We pay for domestic violence either in uncompensated medical care, higher insurance rates or, most unfortunately, the damaged or lost lives of the victims.

Domestic violence is a major public health issue. To address it effectively, it behooves us to learn more about it, identify how we can help to address it, and coordinate our scarce resources to make the biggest impact possible.

Please join us. ★

— Cary Kuhlmann

EDITOR'S NOTE

The Kosovo in Your Own Backyard

The newspapers and television are full of the dreadful images of atrocity, of infuriating strongmen and cowardly bullies, of frustrated statesmen and incompletely applied counterforce. Alarm increases as we realize this is not happening in some primitive culture with little or no governmental structure or sophistication, but in Europe, America's own backyard. It is an affront and a threat. What will happen next?

In 1914, what happened next was World War. In 1937, what happened next was Nazi totalitarianism, the Holocaust, and another world war. In the first case, some argue, catastrophe ensued because the great powers intervened. In the second, others argue just as earnestly, it was because they didn't.

My daughter is taking a college course on the Holocaust. During her spring break, she was assigned the motion picture Schindler's List. We had seen it before, but for whatever reason, the impact was greater for both of us the second time. We talked for days about the dilemmas posed by such monstrous behavior. How could anyone do it? How could anyone tolerate it? How could it be undetected, denied, hidden?

As I write this, it is Holy Week, an important time in my faith. While its culmination is Easter, the proper focus this week is in the darkness, the shadows of human behavior, the evil in the world and the violence it inflicts. It is a framework for viewing any catastrophe, any outrage of brutality and enslavement. It is a time for admitting the dark potential of our natures.

But it gets worse. Such darkness happens not only because of European madmen or cynical power mongers. It happens all around us. This issue of MASA Review contains a heavy dose of the violence all around us: domestic violence, child abuse, homicide. Matters for the district attorney, we may say, or the Department of Human Resources. Not medical problems.

Semantics will not wash our hands clean. Most of us have had that nagging feeling, in the emergency room or the office, that something here just doesn't add up, that the injuries don't match the history, that there is more tension in the air than the situation explains - that there's more here than I'm being told. When it involves a lab test, or an image, we ask the next logical question; we dig deeper. When it involves violence, the temptation is to butt out, to look the other way, not to "choose sides."

We most likely eannot solve the problems in Kosovo. They predate our own nation's history, and the idea that we could control them probably is an illusion. Chances are that we can't rescue every potentially violent situation, either. On the other hand, we can at least talk directly and honestly to our patients. That is the message of "Physicians and Domestic Violence," from the Alabama Coalition Against Domestic Violence. We can insist on the same kind of direct and honest dialog between our association and the public. That is the message from Joel Pittard's "President's Column." And we certainly can be honest with ourselves about what we are seeing. Violence of all sorts has claimed a distressingly high position in the causes of death in our own nation, especially among young people. Maybe it qualifies as a "medical problem," maybe not. Beeause of our unique position as physicians - with our patients and with our society - our responsibilities are just as elear either way.

On a different note, with this issue of MASA Review, we bid a reluctant farewell to Amanda Jones. Amanda has been with the association since 1995, and has served as Managing Editor of our journal since Bill McDonald's retirement in 1998. She leaves us to become the Executive Director of the state optometric association. She has been a creative and hardworking member of our staff, and we wish her well. ★

— William A. Curry, MD, F.A.C.P.

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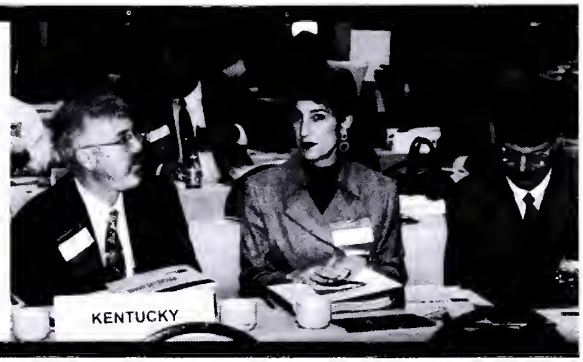

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Domestic Violence

What physicians should know

By Carol Gundlach, Alabama Coalition Against Domestic Violence

Domestic violence is the single greatest cause of injury to women, exceeding automobile accidents, sexual assaults and muggings combined. As a physician, how often do you think you treat victims of domestic violence? All the time? Sometimes? Every now and then? Daily? Never? Would it surprise you to hear that close to four million American women are physically abused each year and that many of them repeatedly seek medical care for that abuse?[1, 2]

Domestic violence is more than a criminal or social problem. It affects all aspects of the community - particularly the medical community where victims seek medical treatment for their injuries and for conditions arising from the abuse. Studies have identified a staggering number of health related problems which can be directly linked to domestic violence. In a study conducted in an urban emergency department it was found that 24 percent of women seen for any reason had a history of domestic violence.[2]

Another study of injured women seen in an inner city emergency department found that 30 percent of female trauma victims were injured due to battering. Many, of these victims suffered lacerations, broken bones, bruises and abrasions requiring hospitalization, burns, internal injuries, vaginal injuries, head injuries, damage to eyes or ears, dental injuries, knife or gunshot wounds, injuries requiring major surgery and injuries that resulted in death.

Domestic violence can manifest in anxiety, depression, suicide attempts, sleep deprivation, smoking, drug and alcohol abuse, poor dietary habits, and nutrition. When victims seek medical help, they often report symptoms affecting numerous organ systems, particularly the gynecologic organs because battering often begins with the onset of pregnancy. Abused women have a higher rate of miscarriage, stillbirths, premature labor, low birth weight babies, and injuries to the fetus, including fractures.[2]

Health providers are in a prime position to intervene with victims of domestic violence and should consider that:

1. Battering is about power and control. It is not about anger, stress, drugs and alcohol, or mental illness. It is essentially and completely about one person's desire to control another using manipulation, scare tactics, emotional, sexual, psychological and physical abuse or any variation thereof.

2. There is no one particular profile of a victim. Victims of domestic violence are not "drawn" to abuse, they do not stay in relationships because they like it, are not mentally ill, and do not always have low self esteem. They come from all walks of life, all religions, all races, all sexual preferences, all professions and all economic back-

grounds, so it is important to be open to the possibility of domestic violence happening to anyone.

3. A victim cannot "just leave" a situation. The reasons for staying in a violent relationship are as various and different as the people who experience the violence. Possible reasons for staying in an abusive relationship can include fear of the perpetrator's violence and the validity of his threats, physical and psychological trauma inflicted by the perpetrator, reasons involving children (e.g. - he takes one child with him wherever he goes so she cannot take both children when she leaves he threatens to hurt or kill the children if she leaves), she is dependent on his health care benefits and his financial income, her religious beliefs, hope that he will stop or change, lack of money and resources, lack of employment experience and fear of not being able to make it on her own or support her children. She believes the abuse is her fault. She may be afraid he will kill her or one of her loved ones if she leaves.

Often, a victim who has previously been told that they needed to learn how to "cope" with the situation or asked what they did to provoke their batterer will be reluctant to disclose the abuse.

4. When treating a possible victim of domestic violence, try to ensure that her partner is not present during the examination. She may be afraid of talking about the cause of her injuries because her batterer is there. If the patient's partner is present when asking questions about injuries be wary if he answers questions for the victim. He may be battering her and wanting to make sure that the abuse is not exposed.

5. Victims of domestic violence are adults who have the right to make their own decisions. Allow them to make decisions for themselves and listen to what they have to say even if you don't agree with their choices.

Physicians must be aware of the revictimization of victims within the system in order to help those seeking help. Because the issue of domestic violence can be a delicate one, it is important to be familiar with the dynamics of violence when helping a victim.

Ideally, the preferred system would include an environment in which battered women could feel safe and secure, one that protected them from their abusers, guaranteed them that the assault and violence they endured was not their fault, and treated their medical and psychological injuries and traumas. Unfortunately, not all health care settings are equipped to provide this environment. Often, a victim who has previously been told that they needed to learn how to "cope" with the situation or asked what they did to provoke their batterer will be reluctant to disclose the abuse. Without direct questioning, victims may not reveal the abuse, even when the cause of injury may be readily apparent. A woman talks about how she felt, abandoned by the system when she sought medical treatment for an injury resulting from violence:[2]

> "They don't talk with you. You can sense it. It's a feeling. It's hard to describe, but automatically- they get quiet. When my eardrum was punctured, I went in for help. I had marks all over me and never once did he [the doctor] ask me [about the abuse], and I was too humiliated to even say — it was almost like you have this feeling that you're the only one, and you feel it's because you made the wrong choice. I thought I was being punished. He only responded to give me medical attention. He never responded to give me any emotional support. Finally he said 'How did this happen?' I said, 'My boyfriend slapped me across the face.' He didn't respond..."

Domestic violence is not an easy issue to address, even when dealing with it often. Physicians are among those who encounter domestic violence frequently and are often looked to for answers, yet can sometimes find themselves at a loss because they may find the topic difficult to approach, have never been trained on the issue, or simply do not know what to say or how to provide further help. This can be a very natural response that is easily overcome with time, understanding and practice. The more often and more openly the issue is addressed, the greater the level of comfort for both physician and patient.

Physicians are in a very important position when responding to domestic violence. They can be merely a link to further assistance or the presiding factor that saves her life. When examining patients, be aware of physical signs: injuries primarily to the face, head, neck, breasts,

abdomen or genitals, injuries during pregnancy or spontaneous abortions. On intake forms include questions such as, "Have you ever been hit kicked, slapped, pushed or shoved by your boyfriend/husband/partner? Are you currently or have you ever been in a relationship where you are physically hurt, threatened, or made to feel afraid?"

When opening the door for discussion about domestic violence with your patients, first try to assess the patient's comfort level with the issue. There are several approaches that can be used. One may be to couch questions in a way that shows the victim that she is not alone and that you are open to what she may have to say. For example, "I don't know if this is a problem for you, but many of the women I see as patients are dealing with abusive relationships. Some are too afraid or uncomfortable to bring it up themselves, so I've started to ask about it routinely," or, "Because so many women I see in my practice are involved with someone who hits them, threatens them, continually puts them down, or tries to control them, I now ask all my patients about abuse." If the situation lends itself to such an approach be specific and direct: "Did someone hit you? Who was it? Was it your partner/husband? Do you feel afraid of your partner? Do you feel you are in danger? Is it safe for you to go home?"

If you feel the topic needs to be introduced more delicately, use indirect questions before proceeding to more direct questions: "Have you been under any stress lately? Are you having any problems with your partner? Do you ever argue or fight? Do you fight physically? Does his behavior frighten you? Does he ever become violent?" If you feel like the patient is masking the abuse, let her know your concerns and that you are there if she needs you. She may be listening to what you have to say without responding and any information you provide her with may still prove to be helpful.

Once the initial assessment is complete and a dialogue has been created with the patient about the violence, it is important to put into her hands information about the systems already in place that can provide further assistance. You can provide her with a social work contact, numbers to the local domestic violence shelter or with Alabama's domestic violence hotline number: 1-800-650-6522 which will connect her direetly with the shelter program in her area and will provide further important information about domestic violence, help her plan for her safety, counsel her about her options, or provide immediate assistance and shelter if needed. Encourage her to use the information you have provided her or return to you if she has any problems in the future. If you feel she is in immediate danger, provide her with a safe place to either call the domestic violence hotline for immediate help, involve a social worker, notify her of any ways she ean escape the immediate situation safely, or call the police.

Who Is Battered?

- More than 50 percent of child abductions result from domestic violence. (Geoffery Grief & Rebecca Hagar, "Abduction of Children By Their Parents: A Survey of the Problem," Social Work, 1991)

- Approximately one out of every 25 elderly persons is victimized annually. (Candace Heisler, Journal of Elder Abuse and Neglect, 1991)

- 22 to 35 percent of women who visit emergency rooms are there for injuries related to on-going abuse. (Journal of the Ameriean Medical Association, 1990)

- Up to 50 percent of all homeless women and children in this country are fleeing domestic violence. (Elizabeth Schneider, Legal Reform Efforts for Battered Women, 1990)

- Five to 25 percent of pregnant women are battered. (Evan Stark & Anne Flitcraft, 1992)

- One out of every four gay couples (25 percent) experienees domestic violence in their relationship. That's approximately the same rate as heterosexual couples. (Family Violence Prevention Fund, 1996)

- A study of violence among dating couples of high school age found that 12 percent had experienced abuse in one of their relationships. (Nona O' Keefe, Karen Brockoff, Esther Chew, "Teen Dating Violence," Social Work, November\December 1986)

- Sexual abuse against disabled girls and women is roughly twice as high as for non-disabled girls and women. Considering that 33 percent of American women experience domestic violence, a conservative estimate says that at least 60 percent of disabled women have experienced it. (New Mobility Magazine, 1995)

- In 1994, 28 percent of the 4,739 women who were murdered were slain by a husband or boyfriend. (FBI)

- According to the U.S. Department of Justice, over two-thirds of female victims of violence documented in 1993 were related to or knew their attacker.

- A 1992 study of family and intimate assaults reported in the Journal of the American Medical Association, found that family and intimate assaults involving firearms are 12 times more likely to result in death than all non-firearm family and intimate assaults.

- A 1993 study in the New England Journal of Family Medicine revealed that homes experiencing domestic violence were close to five times more likely to be the scene of a homicide than other homes. It also reported that a handgun in the home is 43 times more likely to kill a family member or an acquaintance than an intruder.

- The Bureau of Justice reports that although divorced and separated women comprise only 7 percent of the population in the U.S., they account for 75 percent of all battered women and report being assaulted 14 times more often than women still living with a partner.

National Coalition Against Domestic Violence

This article should not be interpreted to mean that the weight of the issue of domestic violence falls on the shoulders of physicians. While physicians are a vital link in exposing domestic violence and safeguarding its victims, they cannot be expected to provide all the answers.

Within this past year, the Alabama Coalition Against Domestic Violence (ACADV) has organized teams of health care providers and others throughout the state to begin implementing programs for screening of patients for domestic violence, for ongoing training for physicians and others on the issue of domestic violence, for developing domestic violence protocols, for the development of resource materials for patients and staff and for developing measures to integrate the institutions' response to domestic violence within the broader community. Each team is made up of representatives from the Alabama Coalition Against Domestic Violence, a nurse, a doctor, a social worker and an administrator from the facility and will be participating over the next three years in the National Health Initiative on Domestic Violence a project of the San Francisco based Family Violence Prevention Fund (FUND). Each of the 15 teams has already been trained by ACADV and the FUND and is in the process of developing long range plans for responding to domestic violence. Participants, include: Kirkland Clinic, Birmingham; University of Alabama, Birmingham; Children's Hospital, Birmingham; Project HELP, Birmingham; West Alabama Health Center, Eutaw; Public Health Area One, Florence; Eliza Coffee Memorial Hospital, Florenee; University of Alabama Huntsville Family Praetice Clinic; Stringfellow Hospital, Anniston: Montgomery Aids Outreach; Baptist Hospital, Montgomery; Poarch Creek Indians Health Center, Atmore; Providence Hospital, Mobile; Franklin Primary Health Center, Mobile; University of South Alabama Medical Center, Mobile; and the University of South Alabama Family Practice, Mobile. Alabama is honored to be one of just ten states chosen to participate in this program.

These teams, your local domestic violence shelter or ACADV can provide you with written and other information on domestic violence and how to eombat it. If you are interested in further information about domestic violence and what you can do as a physician, eall ACADV at (334) 832-4842. ★

Carol Gundlach is the Executive Director of the Alabama Coalition Against Domestic Violence

References

1. According to FBI statistics, 95% of the victims of domestic violence are women and their ehildren.

2. Salber, Patricia R. "Introduction to Improving the Health Care Response to Violence: A Resource manual for Health Care Providers. C. Washaw, A. Ganley. Family Violence Prevention Fund, 1998.

Physician's Reference Guide on Domestic Violence

Common types of injuries found in Emergency Room settings:

- Contusions, abrasions, fractures, sprains, burns
- Face, neck, head, chest, sexual organ, and abdominal injuries
- Multiple sites of injury
- Repeat or chronic injuries
- Any injury where the patient's explanation of injury occurrence is not consistent with the type of injury presented

Common stress related medical problems found in office settings

- Chronic pain without tissue injury
- Sleep disturbances
- Chronic headaches
- Abdominal and gastrointestinal complaints
- Frequent use of prescribed tranquilizers or pain medications
- Anxiety or depression
- Muscular tension
- Suicidal ideas or attempts

Interviewing the Patient

- Think Domestic Violence! Ask the Question! Asking the question may be the most significant role a physician may play in aiding an abused patient to take that first step! Routine screening is vital.
- Examples of questions might include: Is someone at home hurting you? Do you ever feel afraid of your partner?
- Gentle, direct questioning is critical
- Refrain from statements that blame the victim or imply fault
- Interviews must be conducted in private, away from the patient's partner

Documentation

- Thorough, well documented medical records are essential. Medical records regarding injuries should be as precise as possible.

Intervention and Referral

- Recognize that many women minimize the danger of their situation
- Always consider the patient's safety first
- Medical personnel need to explain that without intervention, the abuse will not only continue but escalate
- Let the patient know that help is available by calling the hotline number below

Alabama Domestic Violence Hotline

(1-800-650-6522)

Why do they stay?

By Barbara J. Manning, Ed.D.

One of the greatest frustrations facing doctors, psychologists, counselors, social workers, and other professionals who work with battered women is understanding why they stay in their violent relationships. Why do women who have been brutally beaten by their mates and sought help or treatment return to their mates only to be beaten again and again. Why do they stay with a man who frequently exhibits out-of-control behavior and often has a problem with alcohol and substance abuse, who may also be abusive to the children and possibly inflict his cruelty on helpless animals.

To find some of the answers to these questions, we must first look at the entrapment of a violent relationship and the effects of battering on the victim before discussing the difficulties of leaving. Finally, we should consider how to help women who wish to leave or have left their violent relationship. This article will primarily address the situation of women in extremely violent relationships.

The Entrapment of a Violent Relationship

Violent relationships are frequently formed after a brief courtship. During the courtship period the man is on his best behavior, is romantic and attentive to the woman's desires and interests. The attention seems almost too good to be true and the woman responds favorably to the courting. Once she has committed to him, his behavior changes like a Dr. Jekyll and Mr. Hyde. He can be charming one moment and the devil personified the next He becomes self-centered, demanding, critical, and abusive. His behavior is directed toward gaining power and control over his mate. In the beginning the outside world sees only the charming person.

Psychological Abuse: At first he may use only psychological abuse consisting of verbal put-downs, humiliation, and degradation. He criticizes her looks, her figure, her cooking, her housekeeping, her family and tells her if she only tried harder to be a better mate he wouldn't have to criticize her so often. The criticism may be blatant or subtle. He blames her for everything. He even tells her it is her fault he has trouble at work or her fault he got a DUI after an evening of partying with his friends while she sat at home. Regardless of how hard she tries she can never be perfect enough to win his approval. It is a "no-win" situation.

He is extremely jealous of her and wants her all to himself. He makes it difficult for her have friends or

be with her family members. He does his best to isolate her. They move frequently to accomplish the isolation. He tries to control where she goes and whom she sees. In many cases battered wives are not allowed to go grocery shopping alone or even drive the car. He prefers she stay at home rather than work, even when her ineome is needed to meet basic living expenses. If she does work, he may harass her with constant telephone calls or threaten her at work until she quits or is fired.

He monitors her telephone calls and may even install caller ID to keep further check on her. He usually controls the family finances. Regardless of the economic level battered mates always receive less money than is needed to run a household or maintain a modest lifestyle. He then criticizes her for being a poor manager. In truth, she is probably working miracles with her limited resources. In the meantime, the abuser often spends the family income as he pleases without regard for meeting the needs of his mate and children.

Physical Abuse: Tension is constant in abusive households. When tension reaches a peak, a physically abusive episode can occur without warning. The precipitating event may be real or imagined. The victim does not cause the violence, nor can she prevent the explosive attaek. She may even be attacked while she is asleep. In the early stages of a relationship, he apologizes for his behavior, appears to be genuinely sorry for his actions, and for a brief period is the wonderful person she first loved. Soon the tension again begins to build. There is another explosive incident, which is followed by loving contrition. He blames her for causing the explosion; she tries harder to please him; and the cycle is repeated. The repetition of the cycles reinforces his behavior. The pattern of alternating cycles of negative and pleasurable behavior known as intermittent reinforcement creates a pattern of behavior that is difficult to break. With repetitive cycles there is often no apology and no contrition only tension and the constant threat of brutal physical abuse.

Sexual Abuse: Sexual abuse seems to be present in most abusive relationships. In its mildest form the man merely satisfies his desires without regard for his mate's wishes or needs. His sexual desires are often insatiable and he demands sex constantly. He may have numerous affairs openly or make little effort to hide them. He further humiliates his mate by telling her she's no good and cannot satisfy him. In very violent relationships he rapes her at will, brutally and frequently, with all the horrors and imaginable extremes of aberrant behavior.

Battering and Its Effects[1]

Understanding how an abusive relationship affects the vietims is crucial to understanding why they have difficulty leaving their abusers. No woman can live with constant abuse without experiencing its effects. Battering causes a wide range of traumatic psychological reactions. Violence affects cognitive perceptions, feelings, and behavior. It affects emotional reactions and causes specifie symptoms related to traumatic stress when the victims' normal coping responses are overwhelmed during traumatic events that threaten physical harm or death. Violcnt attacks cause victims to experience intense fear, helplessness and horror. They re-experience the attacks through flashbacks, intrusive thoughts, and dreams. They avoid stimuli associated with the events and experience numbing of general responsiveness. Traumatic stress responses can include dissociation and amnesia resulting in an inability to reeall certain aspeets of the trauma. Altered mental states and dysfunctional behavior can continue long after a vietim experiences traumatic events.

Their self-concept is shattered by the constant humiliation and degradation. When victims are beaten and betrayed by the men they love they withdraw from their friends and family trying to hide their shame and keep the abuse a secret.

Battering results in victims' decreased ability to respond effectively to the violenee and to leave the relationship. When victims perceive they cannot control, predict, or escape the violence they becomes immobilized by the fear and terror and use all their psychic energy merely trying to survive. Victims may appear traumatized, withdrawn, and nonresponsive. Or they may appear agitated or angry. Their suppressed anger leads to depression. They minimize or deny the danger of their situation. They may resort to self-destructive behaviors such as alcohol or drug abuse to ease their pain or choose the ultimate self-destructive behavior, suicide. In such a mental state, victims are unable to take action to help themselves.

Traumatic bonding occurs in a relationship when there is an unequal balance of power. The submissive partner develops a dependency on the person with power. The intermittent reinforcement of alternating pleasant and negative experiences contributes to a strong emotional bond with the abuser and increases dependency. Such a bond is difficult to break.

Difficulties of Leaving the Relationship

Ambivalence About Leaving: Victims experience extreme ambivalence about leaving a violent relationship. Emotionally drained by the violence, victims are vulnerable to the abuser's contrition and promises. They still love their mate and believe his promises to change. They feel the children want and need their father. Family and friends who have little knowledge of the violence may pressure them to try harder to make the relationship work. Victims may be reluctant to give up the support or lose their soeial status.

They constantly weigh the good and bad aspects of their relationship and hesitate to admit failure. Often they are reluctant to leave because of their religious convictions and, if married, their promise to stay "until death do us part."

Dangers of Leaving: If a woman overcomes her ambivalence about leaving she must faee the dangers of leaving. As the violence escalates, abusers often openly threaten to kill their mates if they leave them. Hundreds of women successfully leave their abusive partners each year; but, approximately 1,800 women are killed each year by their abusive partner. The majority are killed as they are trying to leave or after they have left the abusive relationship. The abuser reasons "If I can't have her; no one will." Frequently the children are also killed. Friends or family members who provide safety for the woman and her children are also in danger of harm from the enraged abuser.

About 900 battered women kill their abusers each year in defense of their own lives. The lethal incidents usually occur in direct life or death confrontations with the abusers.

Abusers may also threaten to kidnap their children or gain full custody of them. They regard their mates and children as their property and will do everything in their power to keep from losing them. Children often sabotage their mother's effort to separate. They love their father and want to be with him. After separation or divorce, abusers frequently kidnap their children or obtain custody over them to punish their mates for leaving them. Many children are being raised by abusive fathers who carried out their threats. The mothers deal with the agony of the separation from their children and the knowledge their children are being raised in a violent household. Many women choose to stay with their abusers rather than put their children in such danger.

After their mates leave, abusers frequently harass them incessantly, following them at every turn, breaking into their homes, destroying or damaging possessions, ealling them incessantly, making it difficult for them to remain employed. Women often return after such treatment stating "It is easier to cope with the known dangers than the unknown (dangers)."

Psychological Factors: Their state of mind, perceptions, and beliefs are all faetors affeeting their ability to leave. Their ego strengths are at a low ebb; they may not have the psychic or physical energy to face the dangers of leaving. The constant stress may distort their ability to think rationally or behave reasonably. They are often isolated from family and friends and may have no support system. They survive the violence by denying or minimizing the dangers. They live with constant fear, anxiety and stress whieh take a toll on their physical health. Fragile emotional and physical health are major barriers to leaving.

Economic Factors: Many women hesitate to leave their abusers because of a lack of financial resources. Victims' ability to leave often depends on having a safe place to live. Women who have no place to go, no eurrent job or up-to-date job skills can have difficulty breaking with their source of support and supporting themselves and their children. Often women leave their abusers only to return to their support when they cannot make it on their own financially. A severe illness, a dysfunctional car, or a job loss can quickly destroy their ability to survive away from their abuser.

Criminal Justice System: The response of the criminal jus-

tice system is a crucial element in womens' attempts to leave. The help victims receive depends on their location. Women in rural areas may have limited resources and minimal help available. Extensive domestic violence training for police, magistrates, attorneys, and judges is on-going in Alabama in an effort to improve the help that is available to all victims of domestic violence.

Women often leave numerous times before they leave the relationship the final time. Even after a they leave the relationship and successfully negotiate a separation or divorce, the struggle continues, especially if there are children. Abusers frequently disregard their children's best interests and use the children as pawns in a never ending battle with their former mates. Abusers continue to control their mates in many ways. They may file motion after motion keeping them in court constantly. Often they fail to pay child support. They may ignore their children completely or ignore the rules for visitation. The harassment is never ending.

Helping the Victim

Victims seeking medical help for the injuries inflicted by their mates often evade questions about the cause of their injuries. They are ashamed and afraid to admit the truth They need compassion, comfort, and understanding. Their safety is a primary consideration. They desperately need to be treated with dignity and respect. Often they need information about support systems because in their isolation they may have no knowledge of the help that is available. Individual counseling or battered women's support groups are strongly encouraged to help them sort their options, repair their damaged self-concept and help them gain the emotional strength to make it on their own.

Victims need to know Alabama has a statewide hotline that operates 24 hours a day, 7 days a week. The toll-free number is 1-800-650-6522. Calls will automatically be forwarded to their local domestic violence program or the closest program serving their area. Counselors are waiting to help.

If She Stays

If a woman does not leave an extremely violent relationship, the phrase "Til death do us part" takes on new meaning. When violence escalates to the point the abuser shows no remorse and violence is a constant threat, the potential for lethality is extremely high when there is no intervention or treatment. If the abuser is using drugs or alcohol excessively the risk intensifies. Hundreds of women are serving prisons sentences today because they killed their abusers during a life or death confrontation. In a moment of terror and panic they chose to live. ★

Barbara Manning, Ed.D., is a counselor with extensive experience working with battered women. She has testified as an expert witness on domestic violence in many trials of women who have killed their abusers.

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1. For the past two decades, the specific characteristies and effects of abuse on battered women have been called the "Battered Woman Syndrome." The Violence Against Women Act of 1994 mandated studies on the medical and psychological basis of "Battered Woman Syndrome." Three separate studies found the term "Battered Woman Syndrome" does not adequately reflect the breadth and depth of current empirical and clinical knowledge on the effects of a battering relationship. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV) no longer uses the term to describe anxiety disorders and trauma stress reactions resulting from the battering. The studies recommended the use of the term "Battering and Its Effects" to replace the term "Battered Woman Syndrome."

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Shaken Baby Syndrome

It is estimated that over 1,000 cases of Shaken Baby Syndrome (SBS) are seen in emergency departments in the United States each year. This figure may be low due to a lack of systematic reporting of SBS cases.[1]

Shaken Baby Syndrome is a term used to describe the constellation of signs and symptoms resulting from violent shaking and/or impacting of the head of an infant or small child. The degree of brain damage depends on the amount and duration of the shaking and the forces involved in impact of the head.[2]

No firm answer exists as to the exact number of shakes necessary to create the clinical picture nor for how long a person might typically shake a child in abusive circumstances. Most shaking probably lasts 20 seconds or less, with perhaps as many as 40 to 50 shakes. To cause brain damage sufficient to allow clinical detection of the syndrome, severe force must be used.[2]

In a recent study of victims and perpetrators conducted by SBS Prevention Plus, the age range of shaken babies was one month to four-and-one-half years, with an average of 8.6 months old. Boys were more frequently victims than girls. The perpetrators of SBS were much more likely to be males than females and biological fathers and boyfriends of mothers constituted 67 percent of all shakers. The study suggested that crying was the most frequent triggering event for the violence.[1] Other triggering factors include feeding problems, apnea, toileting problems and jealousy by the adult of the child. Children who died were highly likely to have been in the hands of only one caretaker at the onset of symptoms.[1,3]

Another study showed that when females were perpetrators, they were more likely to be baby-sitters or child care providers than mothers. The reported ages of perpetrators ranged from 13 to 65 years.[3] Many experts agree that most people don't intend to maim or kill children by shaking them. In a number of cases involving a male perpetrator, histories suggested that he was caring for the baby for the first time.

At the 1998 National Conference on Shaken Baby Syndrome, many presenters suggested that SBS is sometimes a one-time event and other times a series of events. An emerging theme from conference presentations was that many children who are severly shaken have been seen in physicians' offices or at a hospital within one week or one month prior to the identification of SBS and that antecedents were missed. These antecedents included such symptoms as vomiting, irri-

tability, lethargy and possible seizures. Missed opportunities for early diagnosis appeared to be more common for the youngest children and for those who ultimately died as a result of shaking injuries. Old injuries and visible bruises, while not necessarily characteristics of SBS cases, were reproted in an average of about half the cases discussed.[3]

The Child Abuse Prevention Center has developed a physician checklist designed as a guide to diagnosing SBS:

Physician Checklist

Shaken Baby Syndrome Characteristics

Most Common Presenting Complaints
•Lethargy
•Seizures
•Decreased Muscle Tone
•Decreased Appetite
•Respiratory Distress
•Vomiting
•Irritability
•Large Head at Four Months

Physical Examination Indications
- Retinal hemorrhaging
- Respiratory distress / arrest--without presence of stridor or lower airway sounds, suggesting CNS origin
- Significant changes in head circumference
- Bulging anterior fontanelle
- Vital sign changes: bardycardia, apnea, hypothermia
- Ear lobe petechia--bruising including adjacent scalp
- Shoulder / neck bruises
- Bruising in non-ambulatory children
- Grasp bruises
- Long-Bone metaphyseal fractures: chip, bucket handle, diaphyseal
- Arm / leg fractures
- Neck / spine bone injuries

Methods of Evaluation
- Funduscopic Examination: Required pupillary dilation with mydriatic agent.
- Lumbar or Subdural Tap: Bloody fluid is a high indicator. If traumatic tap is suspected, spin fluid and check for xanthochromia.
- Misleading Lab Results: Leukocytosis on CBC is sometimes mistaken for meningitis or bacterial sepsis; may need to follow-up with CT scan if indication of Shaken Baby Syndrome is present.
- CT or MRI: Will usually confirm the diagnosis of Shaken Baby Syndrome due to lesions.

The American Academy of Pediatrics has developed a policy statement on shaken baby syndrome that includes clinical guidelines, a portion of which is reprinted here for educational purposes:

Clinical Features and Evaluation

Shaken baby syndrome is characterized as much by what is obscure or subtle as by what is immediately clinically identifiable. A shaken infant may suffer only mild ocular or cerebral trauma. The infant may have a history of poor feeding, vomiting, lethargy, and/or irritability occurring intermittently for days or weeks prior to the time of initial health eare contaet. The subtle symptoms are often minimized by physicians or attributed to mild viral illnesses, feeding dysfunction, or infant colic. Most often one caretaker is aware of the true etiology of the injuries and the others are not. There appears to be a spectrum of the shaken baby syndrome in infancy, and mild cases may never be diagnosed.

The caretaker who violently shakes a young

infant, causing unconsciousness, may put the infant to bed, hoping that the baby will later recover.[5] Thus the opportunity for early therapeutic intervention is often lost.[9] When brought to medical attention, the shaken infant typically is convulsing or comatose, not sucking or swallowing, unable to follow movements, and not smiling or vocalizing. The comatose state may be unrecognized by caretakers and even by some medical providers who may assume that the infant is sleeping or lethargic. Such infants often have respiratory difficulty, progressing to apnea or bradycardia, requiring cardiorespiratory resuscitation.[4,5]

There should be a meticulous search for evidence of other injuries such as bruises. Any such injuries should be documented with photographs and examined sequentially, looking for progression of these bruises or the delayed appearance of other bruises. In 75% to 90% of the cases, unilateral or bilateral retinal hemorrhages are present but may be missed unless the child is examined by a pediatric ophthalmologist or experienced physician who is familiar with the hemorrhages, has the proper equipment, and dilates the child's pupils.[4,5,10] The number, character, and size of retinal hemorrhages following shaking injury vary from case to case. Retinal and vitreous hemorrhages and nonhemorrhagic changes including retinal folds and traumatic retinoschisis are characteristic of shaken baby syndrome.[10,11]

At times the diagnosis is confused with meningitis and a spinal tap yields bloody cerebrospinal fluid. [4] Centrifuged spinal fluid that is xanthochromic should be interpreted to be the result of past cerebral trauma. Because of confusing respiratory symptoms, chest roentgenograms often are obtained, and they may be normal or show unexplained rib fractures. Because blood is lost to the intracranial space, the shaken infant is typically mildly to moderately anemic.[12] Clotting dysfunction should be assessed initially and followed up. Hemorrhagic disease of the newborn due to vitamin K deficiency can present as intracranial bleeding in infants older than one month.[13] Elevated transaminase levels may indicate occult liver injury.[14]

Radiology

Computed tomography (CT) has assumed the first-line role in the imaging evaluation of the brain-injured child. It adequately demonstrates those injuries needing urgent intervention, although some false-negative studies occur, particularly early in the evolution of cerebral edema.[15] The initial CT evaluation should be performed without intravenous contrast and should be assessed by using bone as well as soft tissue windows. Computed tomography is generally the method of choice for demonstrating subarachnoid hemorrhage, mass effect, and large extraaxial hemorrhages.[15] It may need to be repeated after a time interval or if the neurologic picture changes rapidly.[16]

Magnetic resonance imaging (MRI) is of great value as an adjunct to CT in the evaluation of brain injuries in infants.[17] Owing to the lack of universal availability of the technology, the physical limitations of access to MRI when life support is required for the critically ill infant or child, and insensitivity to subarachnoid blood and fractures, MRI is considered complementary to CT. Sato et al have demonstrated a 50 percent improvement in detection of subdural hematoma using MRI as compared with CT.[15] The ability to detect and define intraparenchymal lesions of the brain is substantially improved by the use of MRI. In Sato and coworkers' study CT did not miss any surgically treated injuries that were detected by MRI.[15] Magnetic resonance imaging and CT can date injuries and substantiate repeated injuries by documenting changes in the chemical states of hemoglobin in the affected areas.[15]

A skeletal survey including the long bones, skull, spine, and ribs should be obtained as soon as the infant's medical condition permits. Skull films are complemented by the CT bone windows in the detection of skull fractures. In one retrospective series of abused children, skull films were slightly more sensitive and improved the confidence of diagnosis of skull fracture as compared with CT.[15] Skull fractures that are multiple, are bilateral, or cross suture lines are more likely to be nonaccidental.[18] Single or multiple fractures of the midshaft or metaphysis of long bones or rib fractures may be associated findings. Specialized views coned down may be needed to delineate subtle fractures.[17] A skeletal survey should be repeated in 2 weeks to better delineate new fractures that may not be apparent until they begin to heal (a process that does not begin for 7 to 10 days).[17]

Pathology

The cranial cerebral injuries documented in abused children depend on the force or severity of the shake or shake plus impact and the time elapsed from the injury. Subdural hemorrhage caused by shearing forces disrupting small bridging veins over the surface of the brain is a common result of shaking.[6,7] Such hemorrhage may be most prominent in the interhemispheric fissure and minimal over the convexities of the hemispheres.[5,8] However, cerebral edema with or without subarachnoid hemorrhage may be the only finding. Visible cerebral contusions are unusual, but diffuse axonal injury is probably frequent.[19] Isolated or concomitant hypoxic-ischemic damage may result in mild to severe cerebral edema initially and cerebral atrophy and/or infarction as a later finding. Extracerebral fluid collections over the surface of the brain, cerebral atrophy, and cystic encephalomalacia are common late sequelae.[16]

Previous reports of benign subdural effusions remain unsubstantiated since multidisciplinary evaluations in those cases were lacking.[20]

Outcome/Consequences

There is an extraordinarily high incidence of morbidity and mortality among infant victims of shaking.[12,16] In one series, of those infants who were comatose when initially examined, 60 percent died or had profound mental retardation, spastic quadriplegia, or severe motor dysfunction. Others who initially had seizures, irritability, or lethargy with no lacerations or infarctions of brain tissue, who did not have severe intracranial pressure increases, had subtle neurologic sequelae or persistent seizures.[16] When these severely injured children survive, they may be blind or have chronic subdural fluid collections, enlarging ventricles, cerebral atrophy, encephalomalacia, or porencephalic cysts.[16] The consequence of shaking to infants who do not come to medical attention is presently unknown. ★

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CORRECTION

In the last MASA Review - Volume 2, Number 3, Winter 1998 - the authors of the article "The Disruptive Physician II: The Role of Personality Disorders" should have been listed as:

Charles V. Ford, MD, Professor and Director
University of Alabama at Birmingham
Neuropsychiatry Clinic
Department of Psychiatry and Behavioral Neurobiology
Birmingham, AL

Gerald L. Summer, MD, Medical Director
Physicians Recovery Network
Medical Association of the State of Alabama
Montgomery, AL

The Millennium Bomb

The Y2K (Year 2000) "bug" is a general description of the problem caused by computer software or hardware not being able to correctly recognize the change from the years 1999 to 2000. Why is it a problem and how will it affect us? To understand the significance of the Y2K issue, a little education is in order.

History

The Millennium Bug (known as the Millennium Bomb at the Pentagon) is not really a bug or virus but was an intentional part of the computer's original design. The roots of this are found back in the 1960's and 1970's as computers became more widely used by the government and large businesses. Back then, memory was very expensive and writing programs and developing hardware that made the most efficient use of memory was paramount. It was obvious that recording a year such as 1959 as 59 would save two bytes of memory per instance of use. No one would mistake 59 for 1859 nor 2059. At that time, precious few real world applications regularly necessitated computations against dates in other centuries. Two bytes saved translated into thousands of dollars of hardware space, storage space and computational time.

This shortcut carried over into the development of personal computers in the 1980's. This created few problems until the early 1990's when large companies that dealt with long range planning uncovered an increasing number of errors. Boeing was the first to report a looming problem with date calculations but it wasn't until 1995 that public consciousness was raised to the Y2K problem.

Mea Culpa

So what is the problem? Let's take an example. Let's say you were born in 1938 and you have had money taken out of a lifetime's hard earned paychecks for Social Security. You are looking forward to beginning your retirement benefits in 2001. At the Social Security Administration, software calculates daily retirees' benefits based on age. How does it do this? The software first makes a request from the computer's hardware for the date and since the hardware was developed in the 70's it gets, say, 04-15-99 (remember, the 19 is assumed in 1999). It then looks up your birthday and makes the appropriate calculation. 1999 - 1938 = 61. No retirement benefits yet (but your taxes are due). Fast-forward to 2000. Now you are 62 and have rightfully applied for retirement benefits. The software asks the computer's hardware for the date. It gets 02-14-00. It then makes the appropriate calculation, 1900 - 1938 = -38. Not only are you ineligible for retirement benefits, you don't even exist!

The problem is not limited to a computer's hardware. Until only a few years ago, many software programs were written making the same assumption that 19 would precede any entry in a field requiring a year. Stop and think how much of the world runs on computer programs that have been in place for decades. How long have you been receiving computer generated mortgage payments from the same company? utility bills? bank statements? life insurance amortization schedules? telephone bills? The list goes on and, as I will explain later, touches your life in ways you cannot imagine.

When I was young and impressionable, my grandfather talked me into buying a life insurance policy which I have blindly renewed every year. And every year I have received a dues statement and amortization schedule on the same form printed by the same dot matrix printer since the policy was instated in the 70's (oops, make that *1970*'s). Do you think I suspect my accumulated wealth is in danger? Yes, I do. Am I concerned enough to dissolve this policy? Absolutely (I should have cancelled it years ago for other reasons). Depending on where you live in the world, a telephone call that begins just before midnight Dec. 31, 1999 and ends minutes later on Jan. 1, 2000 will be billed as a 99 year conversation. A eredit card bill owed on Jan. 2, 2000 will become 99 years past due if unpaid on Jan. 1 and, similarly, mortgages will be flagged as default.

Analysis

How will your personal or office computers size up? We can begin by trying to understand exactly what transpires on the motherboard, or hardware, of the computer. Have you ever wondered how your computer always knows the time even when it is unplugged from the wall? This is because of a chip called the Real Time Clock (RTC). It ticks 18.3 times every second and takes its power from a rechargeable battery. It has six registers that constantly update the seconds, minutes, hour, day, month, and last

two digits of the year. It is permanently affixed to the board and thus not replaceable.

When your computer is turned on, another chip called the Basic Input Output System (BIOS) has the job of recognizing and registering all of the components in your computer so that software programs are properly found and know how to access the computer hardware. One of the first jobs of the BIOS is to request the current time from the RTC upon bootup to be passed on for use by any software that might need it. If your computer was manufactured in the past few years, a seventh register containing the century will also be passed back to the BIOS. But most RTC's are still not designed to update the century register at midnight December 31, 1999. So the Y2K problem is not in the BIOS as you often read but in the RTC, and that can't be fixed.

However, the century register in recent RTC's can be overwritten and an intelligent BIOS will recognize if passed a 00 date that it should update the century register from 19 to 20. That is why you read that you should check to see if your computer's BIOS needs to be updated. This is a chip that can be replaced or, in many cases, updated with software. A number of free programs are on the market that will check to see if your computer has an RTC and BIOS that is Y2K compliant, Y2K updateable, or a Y2K doorstop, as well as some commercial programs which offer workarounds for eligible PC's. I direct you to http://www46.hway.net/sutto4/NetsaversCenter/Y2k/download.html and http://www.pcfix2000.com/1_cart/pcfix2k.html. I did this myself and determined that my 1996 Ppro computer will weather the Y2K storm *as long as I turn it off before midnight* and restart it after the blessed midnight event had passed.

Even then your problem is only partially solved. You must then look at the software on your computer and then peruse the web sites of the developers of that software. Many will have sections devoted to Y2K and make statements as to Y2K compliance. There will often be patches or more recent versions available. Accounting software is the most vulnerable and any physician should think long and hard about any billing or patient history system installed before 1998.

The vast majority of pre-DOS 7.0 programs can be discounted as being Y2K non-compliant as well as any PC computer hardware manufactured before 1996. There are exceptions, however. One is the Apple line of computers. The hardware can handle the millennium change, however, the most popular software currently being used are Microsoft programs originally written for the PC but reformatted in order to run on the Mac. You are therefore just as vulnerable as your PC counterparts concerning date calculation problems until you update your software.

To illustrate using another example, the Jefferson County Medical Society's billing system in Birmingham runs on a 1992 IBM RS6000 mini-computer (which is larger and more expensive than a PC but smaller than a mainframe). These were built Y2K compliant. The operating system software is not Microsoft Windows or NT but a flavor of UNIX called AIX. It is not Y2K ready but IBM has supplied an updated version of AIX that eliminates date calculation errors.

Interestingly, there are some tools on the market that evaluate the software on the PC and intercepts/fixes any errant calls for a date calculation (http://hotfiles.zdnet.com/cgi-bin/texis/swlib/hotfiles/info.html) I am more dubious of this as nothing substitutes for a program correctly written from the ground up. We'll wait and see what the jury decides on these programs.

The Rapture

There is a far greater problem that is not as easily within our control and this concerns the issue "embedded systems." There are microprocessors using date functions everywhere around us in the simplest of products and the most complex of industrial operations. These perform automated tasks according to instructions permanently encoded on the chip. Some are easy to see because some sort of date is displayed, such as VCR's, TV's, coffeemakers, and cellular phones. Some are not so easy to appreciate, such as automobile ignition systems, automated power station grid transfer switches, telephone system switches, water plant purification systems, air traffic control radio beacons, railroad track transfer mechanisms, security systems, nuclear power plant cooling operations, IV pumps, ventilators, and rhythm monitors. Some of these systems are embedded in concrete or similarly inaccessible areas. Many of these systems don't rely on a date calculation to perform its intended function, but engineers will often choose to buy a mass-produced processor (with a built-in clock) that performs the functions it needs over a specially designed, more expensive processor that performs *only* the functions it needs. Although the date function may not be used, it is still on the chip, ticking away, measuring the intervals between instructions it receives and forcing a system reset if it perceives an error (such as 00 minus 99). Certain defibrillators and patient monitors have already been identified as having a problem which you can read about at http://www.fda.gov/cdrh/yr2000/y2k99prob.html. The FDA maintains a database of errant devices at http://www.accessdata.fda.gov/y2k/y2k_search.cfm.

Epilogue

Despite some of these and lay press doom and gloom scenarios, this is not the end of civilization as we know it, pri-

marily because major companies are taking the issue very seriously. AT&T has already spent $500 million, Citicorp $650 million, and the IRS nearly $1 billion on this issue, to name a few. The Social Security Administration will not delete people from their databases and has been working on the problem for ten years. I am not worried about my money in the bank nor my investments. However, if I were to identify problem areas, they would be

- the spotty interest that gas, electric, and water utilities have taken in solving their embedded systems problems
- the near complete lack of interest in Y2K by small businesses and local governments
- the impact that poorer countries provided with old technology will have on our economy.

For reasons we won't go into here, the majority of Y2K problems will occur homogenously throughout 1999 and for a few years following. Perhaps less than ten percent of problems will occur with the actual date rollover.

The bottom line is that you should take this issue seriously for your own business. Inquire of your billing company's interest in the problem and what steps they have taken to examine their own systems and software. Keep good written documentation of personal and business transactions during the latter half of 1999. Keep zero credit card balances and request written verification of payment schedules during this time. And, if you plan a big party on New Year's Eve, remember that the new millenium doesn't really start until 2001!

Resources

For a general listing of the impact of Y2K on various industries, visit www.zdnet.com/zdy2k/resources.html. For your personal enjoyment, read an apocalyptic's view of Y2K at http://www.garynorth.com, then read the opposing views at http://nova.smu.edu/garynorth.htm and http://www.angelfire.com/oh/justanumber. For a more balanced appreciation of the Y2K problem, visit http://www.pathfinder.com/money/y2k. ★

Any questions? You can contact me at frisbie@csi.com.

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THIRD PARTY TASK FORCE
The Third Party Task Force is a committee of MASA which consists of physician members who provide assistance to other physicians in resolving issues and disputes with insurance companies, HMOs, other third party payors, including Medicaid and Medicare, and other peer review organizations. Member physicians requiring the assistance of the Task Force should send a letter detailing the nature of the dispute and copies of relevant correspondence or medical records to MASA. *Contact: Wendell Morgan 1-800-239-6272*

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The Physicians Recovery Network promotes the early identification, evaluation, and treatment of physicians who may be impaired as a result of mental/emotional illness, or substance abuse/dependence. A documented program of recovery is offered to enable these physicians to return to practice. The PRN staff is available to present several educational programs suitable for all audiences. *Contact: Jerry Summer, M.D., 1-800-239-6272*

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MASA endorses Blue Cross Blue Shield group health insuranee plans for you and your staff.
Contact: Emmett Wyatt, MASA 1-800-239-6272

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United Communications Group offers newsletters and other publications to help physieians, including: Part B News, Part B Answer Book, Practice Strategies for Managed Care, Physician Practice Coder, RBRVS FeeCalc software, Medicare Compliance Alert and Physician Office Lab News. Exclusive MASA discount available. *Contact: United Communication Group, 1-800-929-4824, Ext. 2238*

Q: For what reasons can I terminate a relationship with a patient? Are there any standard procedures I should abide by when terminating a relationship?

A: When you establish a relationship with a patient, you also take on the duty to treat the individual until the relationship is terminated. Termination can occur for several reasons and either the patient or the physician can initiate termination. Physicians withdraw from patient relationships for a variety of reasons including patient noncompliance with recommended treatment, patent failure to meet financial obligations and a physician's retirement or change in practice site. The one instance in which the physician cannot terminate the care is in an emergency. However, ending a relationship with a patient could lead to an abandonment claim by the patient. A clear, concise, well-documented termination with reasonable notice will fortify the physician's defense.

Remember, each termination should be viewed and treated on an individual basis. Consideration of the patient's medical problem and the availability of qualified care should be given before terminating care. If possible, the physician then should personally discuss the reason for terminating care with the patient. After speaking with the patient, a written notification should be sent, via certified mail, confirming the termination of care. The discussion and the letter's mailing should be documented in the patient's record.

The discussion with the patient, documentation in the record concerning the discussion and the termination letter should include the following:

- referral sources to obtain new medical care-such as a county medical society

- amount of time that treatment will continue. A reasonable length of time should be provided for the patient to arrange services by another physician. In most situations, 30 days notification to the patient is adequate. In some cases, this length of time may not be appropriate due to the patient's present health condition.

- the procedure for obtaining a copy of the patient's medical record. This can be done upon receipt of a written request (a free copy is recommended). Generally, copies of the record should not be withheld if the patient has not paid for all previous services. Physicians also should consider the requirements or terms pertaining to any payment or agreed contracts.

- information concerning the patient's health if the patient has an illness which may require follow-up care ★

Physicians insured by Mutual Assurance, MASA's endorsed professional liability carrier, may contact the company's Risk Resource Center for answers to liability questions and/or risk management by calling (800)282-6242 or via email at rmhelp@maih.com.

Mutual Assurance Defense Philosophy Pays Off

How effective is Mutual Assurance in representing policyholders who have claims? A recent analysis of claims' outcomes from 1990-1997 finds that Mutual Assurance closed 93.2% of claims without a loss payment. That is in marked contrast with other writers of malpractice insurance in Alabama. For example, using the same analysis of statutory filing data, Coastal closed 66.1% of its cases with some type of indemnity payment; St. Paul closed 75.1% of its cases during that eight year span with a loss payment.

This success ratio is especially critieal in the face of the number of frivolous lawsuits being filed every year. Couple that with proposals to open the National Practitioner Data Bank to the public and broaden the scope and type of payments that must be reported to the Data Bank and the need for a strong, successful defense has never been more apparent.

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Style: The first page should list title, the author(s), degrees and any institutional or other credits. Bibliographies must contain, in the order given: Name of author, title of article, name of periodicals with volume, page, month - day of month if weekly - and year. References should be numbered consecutively in order in which they appear in the text.

Length of Articles: Articles should not exceed 10 printed pages.

Illustrations: Illustrations should be numbered consecutively and indicated in the text. The number, indication of the top and the author's name should be attached to the back of each illustration. Legend should be typed, numbered, and attached to each illustration. Photographs should be clear and distinct; drawings should be made in black ink on white paper. For photographs, glossy prints are preferred.

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upcoming

APRIL

April 7-11
General Surgery Update
Hilton Head Island SC
Contact: George M. Converse, MD
(205) 783-5276
CME Credit: 19 hours Category 1

April 20-21
MASA Board of Censors
Montgomery, AL

April 21-24
Pediatrics Update
Hilton Head Island SC
Contact: George M. Converse, MD
(205) 783-5276
CME Credit: 15 hours Category 1

April 23-24
17th Annual Review of Modern
Therapeutics
Huntsville, AL
Contact: UAB CME Office - Huntsville (256) 551-4490

April 27 - 29
AMASA Convention
Mobile, AL

MAY

May 18-19
MASA Board of Censors
Montgomery, AL

JUNE

June 8-12
General Surgery Seminar
Hilton Head Island SC
Contact: George M. Converse, MD
(205) 783-5276
CME Credit: 19 hours Category 1

June 6-11
Alabama Academy of Family Physicians Annual Meeting
Pine Mountain GA
Contact: Holley Midgley (334) 263-6441

June 10-13
1999 MASA Annual Session
Marriott Bay Point, Florida
Contact:MASA Education Department (334) 263-6441 or
(800) 239-6272

June 14-16
16th Annual Alabama Chapter, Am.
College of Emergency Physicians
Annual Meeting & Education Session
Destin FL
Contact: Dr. David Garvey or Leland
Holman (334) 265-0068

events

June 15-19
Adult Infectious Disease Seminar
Hilton Head Island, SC
Contact: George M. Converse, MD
(205) 783-5276
CME Credit: 19 hours Category 1

June 22-26
Pediatric Infectious Disease Seminar
Hilton Head Island, SC
Contact: George M. Converse, MD (205) 783-5276
CME Credit: 19 hours Category 1

June 24-27
Dermatology on the Beach
Destin, FL
Contact: Eric W. Baum, MD (256) 543-2380
CME Credit: 15 hours of Category 1

June 29 - July 3
Family Practice Seminar
Hilton Head Island, SC
Contact: George M. Converse, MD (205) 783-5276
CME Credit: 19 hours Category 1

JULY

July 6-10
Anesthesiology Update
Hilton Head Island, SC
Contact: George M. Converse, MD (205) 783-5276
CME Credit: 19 hours Category 1

July 13-17
Internal Medicine Update
Hilton Head Island, SC
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OCTOBER

October 10-13
Current Clinical Internal Medicine Seminar
Lake Buena Vista, FL
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October 13-16
Pediatric Infectious Disease Seminar
Lake Buena Vista, FL
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CME Credit: 15 hours Category 1

October 28-31
Internal Medicine Seminar
White Sulphur Springs, WV
Contact: George M. Converse, MD (205) 783-5276
CME Credit: 15 hours Category 1

BOOK REVIEW

Jerome Cochran His Life, His Works, His Legacy

By John T. Morris, B.S., MD and
Barbara Ann McClary, B.S., R.N.
The Mulberry River Press
1316 Legion Drive NW
Cullman, Alabama 35055
313 pages ISBN 0-9636529-3-1

This biography of the founder of modern medicine in Alabama offers a wealth of information about this remarkable physician. Much of the basic infrastructure of medicine in our state emanates from the remarkable tenacity and vision of Jerome Cochran, MD. His contributions include setting the foundations of public health and the state medical association in Alabama. His deeds are richly chronicled in this well researched volume.

In addition to his remarkable feats in the field of medicine, he was an exemplary citizen. He was devoted to his family and church, a devout Catholic. He persevered to the end despite great personal loss. His wife and six of his children preceded him in death. Always, he kept to his vision. One eulogy stated that "He was firm almost to obstinacy, and unselfish almost to the verge of improvidence."

He had strong views on almost every subject. He frequently stepped on toes. He could be sarcastic. He was unrelenting in his quests, and he was successful. There was also a moderating side to his forcefulness. He wrote about those who opposed his views on abortion that "I have no words of censure for those who in good faith and with conscience void of offense have reached conclusions different from mine."

Dr. Cochran believed in organized medicine always striving for the highest standards of technical perfection. He urged practicing physicians to share their experiences in journals as a way of learning. He demanded that medical schools be worthy institutions long before the Flexner Report. He taught high morals and a sense of altruism. Balancing these erstwhile efforts, he felt doctors ought to direct and regulate medical care as those most qualified and caring.

He would surely cringe to see modern medicine being run by businesses and physicians being taught to be business associates with stethoscopes. We would never hear the end of it.

After his death, the Medical Association agreed to erect a "suitable monument" to be placed on "the Capitol grounds at Montgomery." The plan never reached fruition. In 1898, Dr. Luther Leonidas Hill, then president of the Medical Association, proposed the "Jerome Cochran Oration," which continues to this day. This biography is a further tribute to a great physician and a great Alabamian. You will benefit from reading this book. ★

Reviewed by David W. Hodo, M.D.
Book Editor

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President, *continued from page two*

for. Perhaps perpetrators of violent crimes are in a constant "malaise" and must have this kind of excitement or impending doom to arouse them. And like the force of natural disasters, they destroy what's in their paths.

Why is violence so pervasive in our society? Our children are exposed to violence daily in the form of computer games, TV and the movies which tend to trivialize murder and destruction of property. It has been suggested that Jesse (the Body, the Mind) Ventura did not win the Minnesota governorship because he provided a relief from the "politics as usual" mentality of the other candidates, but rather because he was a professional wrestler and professional wrestling is very popular, garnering seven of the top nine cable TV slots. People voted who previously never had been inside a voting booth. If you've ever watched professional wrestling you realize that even though it is an act, it very much promotes violence and hostility, as do many other sports which frequently appeal to kids. As a society, we often ignore or condone this constant barrage.

Another catalyst for violent behavior is substance abuse - drugs, alcohol, and tobacco. There's been a recent dramatic increase in heroin use in teens which has public health officials worried, even though their relative numbers are low. There's also been a recent increase in binge drinking on college campuses and elsewhere with a resultant increase in violenee. New studies indicate that smokers are more likely to be involved in violent acts compared to non-smokers.

Violence is a multifaceted problem, touching all our lives. Medicine alone cannot come up with the solutions to this problem, but we must work with law enforcement, government agencies, social workers, educators and a myriad of others. Difficult problems require difficult solutions, but that has never deterred physicians from seeking them in other areas. Otherwise, we wouldn't have antibiotics, immunizations and other great innovations we have developed to make us healthier.

What has organized medicine done and what will we do in the future? To solve the problem requires taking small steps and targeting the areas where we ean make an impact. The AMA along with several state and specialty societies has met with the Justice Department to assure that the government is doing everything possible to protect physicians against terrorists who target doctors They also formed a crisis team to alert physicians who are targeted by Mr. Horsley's web site and to give them appropriate contacts with law enforcement agencies. In the area of school violence, the AMA house passed resolutions requiring mental health evaluation of any student found carrying a weapon, researching school violence and providing rcsources for domestic violence education. They also passed a resolution supporting legislation requiring gun owners to be legally responsible for any accident caused by a child gaining unsupervised access to their guns.

At the state level, MASA has joined with the Alliance in promoting the SAVE program (Stop America's Violence Everywhere), kicked off recently in Orange Beach with a training program for doctors and other health workers. The purpose was to train doctors in recognition of and response to domestic violence. Part of that program is the "Physician Reference Card," which the Alliance is distributing for the second consecutive year to physicians throughout Alabama. This is a simple, effective means of getting this important message to physicians: Talk with your patient; think about domestic violence; ask the question!

MASA also held a press conference promoting the program in eonjunction with the Alliance and The Coalition Against Domestic Violence. Medical facilities across the state are participating in this ongoing project. Our primary goal is to bring domestic violenee to the forefront in the medical community.

Physicians, particularly those who practice in primary care and emergeney settings, are in a unique position to make a difference in addressing this problem with early intervention. Simply asking the question of a patient who may be in an abusive relationship is perhaps the most significant role a physician can play. It can be as simple as asking, "Is someone at home hurting you?"

MASA is also working on a project to prevent teen pregnancy, which is in its developmental stages. Why is this important, and how is it connected to violence? Nineteen percent of births in Alabama are to teens, less than thirty percent of whom are married and who raise their children without the benefit of a father figure in the home. These tend to be the children who get into trouble from early childhood and who are more likely to be involved in crime and violence. Postponing pregnancy until these mothers are more mature and financially able to provide for their children could make an important difference.

These are small steps toward addressing a complex issue with no simple solutions. They will provide a foundation for future work in other areas of violence prevention. Awareness, education, and involvement ...those are a good beginning. ★

PRACTICE MANAGEMENT

Arguing for the Art of Medicine and Management

I appreciate those physicians who were inclined to make contact with some suggestions as to other subjects that would be helpful in this series of articles as they work to manage their own practices. Most of these comments came from physicians who have the dual role of patient care and primary responsibility for managing their own staffs and daily practice operations. One particularly intriguing question was raised by a solo primary care physician who asked whether or not I recommend a practice have an employee handbook or a formal policies and procedures manual.

I found this question particularly interesting because I have been wrestling with the pros and cons of this issue for some time. The truth is, the answers to many management questions are colored by the role the respondent plays in the management mix. What follows here will likely make my attorney friends uncomfortable, and probably flies in the face of conventional wisdom. I am not suggesting that I do not value the input of the outside advisors retained by our practice. They are in fact trusted active members of our management team. As our accountant or attorneys, they have their own roles to play and often take on the part of "Devil's Advocate" in evaluating the risk management arm of our practice. They would make the argument that we need to have everything documented. In essence, creating a code book of rules to live by that protect both our employees and the practice and keeps us in line with the myriad of federal and state regulations.

"...the fact is that employees, like patients, are not cookie cutter cogs in the machinery of our daily practice operations."

From that perspective, I would agree with them. Complianee is the medieal buzz word of the late nineties and while it is now linked principally with reimbursement issues, those physicians and managers who have been working with employees in medieal practiee for any length of time will say that compliance has long been a part of their lives in the area of employment law. To that end, the answer to the physician's question is an unequivocal yes. We need to have clearly documented policies and procedures for being in compliance with our responsibilities as employers. We ought to be clear both with our owners/partners and with our staff that there is no place in our practices for sexual harassment, substance abuse, employee dishonesty, breaches of confidentiality, etc. Our policies must be documented, must be clear and concise, and should provide the guidelines whereby either an employee or the practice could seek remedy should something go awry. While there are many "canned" manuals that can be adapted to fit a particular practice situation, whatever we propose to adopt should always be approved by our legal advisors. Ours constantly remind me not to put them in the position of having to defend us after the fact when they had no input as to how we were choosing to handle a particular situation.

Again, compliance mandates documentation. It is as we move beyond the specific compliance issues into the worlds of policies and procedures designed to channel individual behavior and agendas for the good of the whole that I begin to chafe under the mantel of "the manual"

One of the most interesting paradoxes regarding employee handbooks is that staff tend to love them if it benefits them, and rail at the unfairness of the very same policies if something happens and they become a victim of the rules. Employees oftentimes want an extensive handbook of do's and dont's in hopes that it keeps them from being taken advantage of. If you don't believe that, simply make a decision that is outside the letter of the law and see how long it takes for someone to confront you with the fact that "that is not in the book." At the same time, physician and managers alike oftentimes like extensive policies and procedures because they take away the sometimes heart wrenching difficulty of dealing with certain situations based on their own merits and circumstances. I have administrator friends and some casual acquaintances that have had long and distinguished careers managing "by the book." In those settings, rules are consistently applied and the rules are the rules. Their staff turnover rates may be higher than they might wish, but they consider that a fair compromise as opposed to the potential chaos that sometimes accompanies a less rigid management style.

Over the years, our physicians have patiently taught me about both the science and the art of medicine. During that time I have come to appreciate their command of the

seience, but have gained an even greater respect for their mastery of the art of medicine. Hence, the title of this article. Part of my response to the original question is to suggest that there should also be an "art" to management that cannot be confined to policies and procedures.

Just as the medical profession has rightly resisted unhealthy effort on the part of some to reduce medicine to a science of applied protocols, "cookbook medicine" if you will. I submit that there has been far less concern expressed that management would fall victim to the same disease. While the compliance argument makes the case for effeetive and thorough documentation of major policies and procedures, the fact is that employees, like patients, are not cookie cutter cogs in the machinery of our daily practiee operations. They are people who, like the rest of us, might like life in a black and white world but are forever confronted with the reality that much of life is lived out in various shades of gray. I would suggest that policies and procedures are great for the limited security that they can provide, but they have the potential to be major encumbranees to effectively managing people with compassion and understanding in helping them to reach their fullest potential.

The truth of the matter is that there is an art to management that does not need to be lost in this era of risk management and compliance. Are there risks in leaving the black and white world of handbooks and manuals to deal with human situations as conscience dictates? There certainly are. (I can feel our legal counsel getting nervous already.) Onee we begin to venture into those gray areas, those events of life that are oftentimes beyond anyone's control, we lose the security of treating everyone the same. We have to become comfortable with the difference between equal and equitable. Sooner or later the gray area owner/manager will be accused of being biased because the rules and policies may be interpreted in light of the situation in eontrast to the black and white owner or manager who may never be accused of being biased, but will often be accused and perhaps found guilty of being unfeeling.

A new acquaintance recently shared with me that when writing and adopting personnel policies and procedures we often succumb to the danger of writing the rules to deal with every worse ease scenario that anyone has ever imagined or actually experienced. He argues that what we need to do is design our policies and proeedures based on the actions and habits of our very best employee(s); thereby establishing the high ground of expectation for performance within our practice or business. After reflecting on that wonderful insight, I can't help but believe that we can probably reduce our manuals by fifty percent of their total volume simply by emphasizing what we do want instead of the endless list of things that we don't want and can't accept. Like medicine then, there is both science and art to management. There is a danger that our preoccupation with risks in this litigious world in which we live and work may result in our becoming managerial technicians who resemble the Tin Man of Oz in need of a heart. Honestly, I sometimes envy those who can successfully manage in a black and white, yes and no world, where I am sure decisions come faster and are easier to justify. Fortunately, or unfortunately, depending on one's perspective, I am not one of them. I believe that as business owners, physieian/managers and/or professional administrators, the people side of our jobs require us to make decisions and value judgments in applying the rules to situations that are never uniform. To do so, we have to become comfortable with being able to pass the mirror test. That is to say, when we look ourselves in the mirror at the end of the day for that committee meeting of two, can we answer in the affirmative "Was I fair in my decisions today?"

Beyond that, our challenge is for us all, ineluding my attorney friends, to be willing to color some of the pages gray, and to educate our employees as to why they would really rather it be that way. You, as physicians, are healers by nature and training. If we can exhibit compassion to our patients why would we not reserve for ourselves the same freedom to do what compassion and reason dictates in relationship with our employees. Admittedly, this is the road less traveled and not without its own perils. I believe the rewards justify the risks. Good luck.

Dan Bailey, CMPE, is the Executive Director for Women's HealthCare of Dothan, P.C., a nine physician OB/GYN practice and serves as the 1998-99 President of the Medical Group Management Association of Alabama. If there are management issues that you would like to see addressed in this series of articles, please communicate your request to Amanda Jones, amanda@masalink.org or 1-800-239-6272.

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Medicaid-yet another funding crisis

Early this year Sergio Stagno, MD, chairman of the Pediatrics Department at UAB, appealed to MASA for help with a crisis. Jefferson County had just started the Patient First program and thousands of beneficiaries were now in a "medical home." Unfortunately, most of these beneficiaries either did not know who their primary care physicians were or were not educated enough about the system to know that they required authorization to be seen in the Emergency Room. The problem: thousands of unauthorized visits to the Children's Hospital ER for which the hospital and the physicians could get no funding. A large team of clerical workers was hired to attempt to discover and locate the primary care physicians and try to get authorization for the visits. This met with limited success with many of the physicians saying that they had never seen the patient and did not know if the visit was justified. Other physicians just denied the approval. This was the proverbial last straw.

To make things worse, Medicaid funding for emergency visits is abysmally poor, even when paid. The most common visit code for Children's Hospital ER is a level 3 and Medicaid pays only $21 versus $30 for a level 3 office visit and Medicare's $57 for a level 3 ER visit. Other specialists have funding problems also; e.g. anesthesiologists receive only 10 -12 percent of their billings for Medicaid patients.

Due to this severe payment crisis UAB Pediatrics, which provides the majority of care for Children's Emergency and its more complex subspecialty and long term care, was working for less than their costs and, as a result, they were losing valuable physicians and faculty members. Ultimately, Children's Hospital was in danger of losing its physician coverage and one of the state's great medical resources could have been lost. Of course, not only Medicaid recipients, but also privately funded patients would have been the losers if the state's premier children's referral center did not survive.

In response, MASA formed a core group with the Alabama Hospital Association, the Alabama chapter of the American College of Emergency Physicians, Jefferson County Medical Society, UAB Pediatrics, and Children's Hospital, and visited Acting Medicaid Commissioner Dale Walley. To date, we have been able to get the requirement waived for primary care physician authorization for certified emergency visits (using the prudent lay person definition). This goes a long way toward alleviating the short term problem, being a small, but essential, first step until the Patient First program can get its beneficiaries and physicians educated about their system requirements. Our members and their patients around the state will benefit from this relief as well.

But what of the long term problem of chronic under funding of Medicaid? Under Federal guidelines, states establish their own standards for eligibility. Alabama has set its eligibility cap at an income less than $333 a month, 22 percent of the federally defined poverty level of $16,450 per year for a family of four and the lowest of all the states! At this level, very few are eligible for Medicaid. In fact, I have been told by those in charge of enrolling Medicaid recipients, that the only way an adult can get Medicaid is by their being determined to be disabled by the Social Security Administration. This certainly eliminates the vast majority of the working poor from the program.

On the other hand, eligibility for children has been given a big boost by the Federal Children's Health Insurance Program (CHIP). Each state was allowed to set up its own program under certain federal guidelines. With MASA's assistance and under the leadership of State Health Officer Don Williamson, MD, Alabama set up the first program in the nation and the state legislature funded it for the first year at $5 million with a large Federal match. For children at or below 100 percent of the federally defined poverty level, it meant extending eligibility for Medicaid to the 14 through 18 year old population, who had been previously uncovered. For those between 100 and 200 percent of the poverty level, it meant private insurance for children from birth through eighteen years of age. The irony is that there was such a rush to get on the latter program, literally thousands of children were found eligible for Medicaid instead, causing another crunch in the Medicaid budget. Additionally, there is a tremendous backlog getting these children enrolled, due to bureaucratic requirements.

CHIP is such a good investment we must take advantage of it. There is a federal match of almost four dollars

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— Joel C. Pittard, MD, Immediate Past President

MASA advocates for Medicaid funding

The Alabama Legislature approved a plan pushed by MASA and other health providers that earmarks a significant portion of Alabama's tobacco settlement money for Medicaid.

The final version of the legislation represents a compromise between advocates of Children's First initiatives and health providers who insisted that tobacco money be spent on healthcare. Despite negative publicity from many of the state's newspapers, the Legislature supported MASA's efforts to allocate funds for Medicaid.

Specifically, the legislation directs approximately $40 million a year of the tobacco money to be appropriated to Medicaid. This figure will increase up to $45 million in those years in which the settlement money is due to increase. In addition, the bill specifies that the Legislature cannot supplant traditional appropriations from the General Fund to the Medicaid agency with the tobacco money.

Prior to passage of the legislation, MASA was sharply and wrongly criticized through several editorials for not publicly supporting the Children's First legislation. In response, MASA sent letters to the editor to all the daily newspapers throughout the state. A eopy of the letter follows:

Dear Editor,

This legislative session, the Medical Association of the State of Alabama has come under editorial attack for allegedly failing to support Children's First. That is simply not true. As a member of the Coalition for a Tobacco Free Alabama, we supported the eoneept of the Children's First program. However, as an association of more than 6,200 physicians who know first-hand the crippling state of our Medicaid system, we encouraged supporters of Children First to include desperately needed funding for Medicaid when a tobacco tax was proposed. No such funding was included and the Medical Association took a seat on the sidelines.

Now comes the issue of the tobacco settlement monies and the Medical Association is painted as a "Johnny come lately," looking for a piece of the pie. Nothing could be farther from the truth. The intent of the tobacco settlement monies is to repay states for their past and future expenditures for tobacco related illnesses as well as public health initiatives—period. It makes good sense that some reasonable portion go to shore up an ailing Medicaid system and to provide additional funding for ALL Kids, the private insurance program for children which comes under the umbrella of the Children's Health Insurance Program (CHIP) initiative. It makes especially good sense when you think about Medicaid budget allocations being matched 2.33 to 1 with federal dollars and CHIP enjoying an even higher 4 to 1 federal match.

What sort of numbers are we talking about? Since ALL Kids was started (it should be noted that Alabama, with support from a broad based coalition which included the Medical Association and Children's First, was the first state in the nation to have its program up and running) it has not only enrolled over 19,000 children who previously had no insurance, but it also identified some 16,000 children who were eligible for Medicaid. Think about it—there was no outreach to eligible children because Alabama's Medicaid system could not handle the influx of new beneficiaries without more funding. Now, more than 16,000 children are looking to Medicaid for medical care. So, when the rest of the eligible children needing to be served by Medicaid are actually enrolled, where does the money come from to pay for them?

Our association has worked hard to ensure that the children of this state, the children in your community, have access to health care. That is why we stood firm on our goal of seeking more funding for Medicaid. Yes, we need innovative programs like those proposed in Children's First. Adequate funding is needed for improved access to day care, community resource centers, alternative schools and foster care. But we cannot neglect our children's health by failing to ensure Medicaid has the funding it needs. Thanks to our legislators' wisdom, they have passed legislation which will take a significant portion of the tobacco settlement and earmark funding for Medicaid. Now Medicaid will receive at least $40 million, which, when matched with federal funds, becomes $133 million dollars. That's a start, but as we look even longer into the future, the Medicaid system will need even more serious

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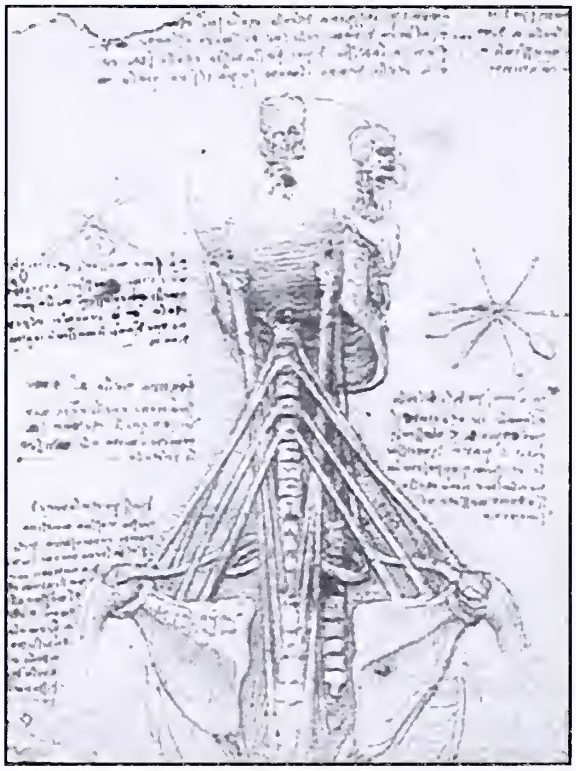
— Cary Kuhlmann

Medicaid: A national perspective

by Mary Onnis Ward
Health Care Financing Administration
and MASA staff reports

As early as 1915, efforts began to establish government health insurance programs. From the 1930s on, there was agreement on the real need for some form of health insurance to alleviate the unpredictable and uneven incidence of medical costs. The main health care issue at that time was whether health insurance should be privately or publicly financed.



Private health insurance expanded rapidly during World War II, when fringe benefits were increased to compensate for government limits on direct wage increases. This trend continued after the war, in part due to the favorable tax treatment of providing compensation in the form of fringe benefits. Private health insurance was especially needed and wanted by middle-income people. Yet not everyone could obtain or afford private health insurance. Government involvement was sought. Various national health insurance plans, financed by payroll taxes, were proposed in Congress starting in the 1940s; however, none was ever brought to a vote.

In 1950, Congress acted to improve access to medical care for needy persons who were receiving public assistance. This permitted, for the first time, federal participation in the financing of state payments to the providers of medical care for costs incurred by public assistance recipients. In 1960, the Kerr-Mills bill provided medical assistance for aged persons who were not so poor, yet still needed assistance with medical expenses. But a more comprehensive improvement in the provision of medical care, especially for the elderly, became a major congressional priority.

After consideration of various approaches, and after lengthy national debate, Congress passed legislation in 1965 establishing the Medicare and the Medicaid programs as Title XVIII and Title XIX of the Social Security Act. Medicare was established in response to the specific medical care needs of the elderly (and in 1973, the severely disabled and certain persons with kidney disease). Medicaid was established in response to the widely perceived inadequacy of "welfare medical care" under public assistance. In 1977, the Health Care Financing Administration (HCFA) was established under the Department of Health and Human Services to administer the Medicare and Medicaid programs.

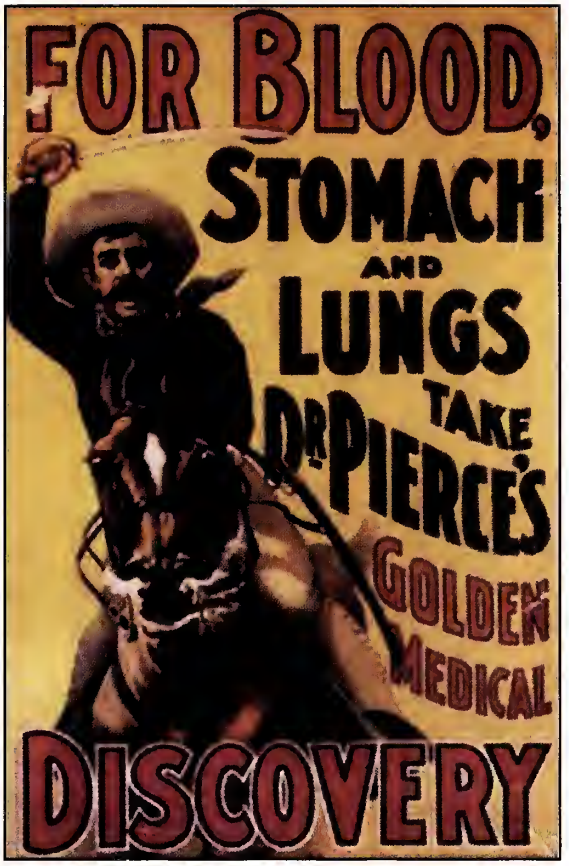
Medicaid and Medicare now make up the largest shares of public health expenditures. Together, Medicare and Medicaid financed $351 billion in health care services in 1996—more than one-third of the nation's total health care bill and almost three-quarters of all public spending on health care. Since their enactment, both Medicare and Medicaid have been subject to numerous legislative and administrative changes designed to make improvements, with financial considerations, in the provision of health care services.

Medicaid is made law

Medicaid became law in 1965 as a jointly funded cooperative venture between the federal and state governments to assist states furnishing medical assistance to eligible needy persons and is the largest source of funding for medical and health-related services for America's poorest people. In 1996, it provided health care assistance to more

than 36 million persons, at a cost of $160 billion dollars.

Within broad national guidelines established by federal statutes, regulations and policies, each state establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program. Medicaid policies for eligibility, services, and payment are complex, and vary considerably even from state to state. As a result, a person who is eligible for Medicaid in one state might not be eligible in another state; and the services provided by one state may differ considerably in amount, duration, or scope as that of a neighboring state.



Medicaid does not provide medical assistance for all poor persons. Indeed, the proportion of Americans without insurance has continued to increase from 14.2 percent in 1995 to 16.1 percent in 1997. That translates to 43.1 million Americans who are without any type of health insurance.

States generally have broad discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility as well as reimbursement criteria. To be eligible for federal funds, however, states are *required* to provide Medicaid coverage for certain individuals who receive federally assisted income-maintenance payments, as well as for related groups not receiving cash payments.

Welfare reform plays a role

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193) — known as the "welfare reform" bill — made restrictive changes regarding eligibility for Supplemental Security Income (SSI) coverage that impacted on the Medieaid program. For most legal resident aliens and other qualified aliens who entered the United States on or after August 22, 1996, Medicaid is barred for five years. A number of children with disabilities lost SSI as a result of welfare reform, but were covered under the Balanced Budget Act of 1997 (the BBA).

In addition, welfare reform repealed the open-ended federal entitlement program known as Aid to Families with Dependent Children (AFDC), and replaeed it with Temporary Assistance for Needy Families (TANF), which will provide grants to states to be spent on time-limited cash assistance. TANF limits a family's lifetime cash welfare benefits to a maximum of five years, and permits states to impose a wide range of other restrictions as well —in particular, requirements related to employment.

Title XXI of the Soeial Security Act, known as the Children's Health Insuranee Program (CHIP), is a new program initiated by the BBA. In addition to allowing states to craft or expand an existing state insurance program, CHIP will provide more federal funds for states to expand Medicaid eligibility to include more children who are currently uninsured. With certain exceptions, these are low-income children who would not qualify for Medicaid based on the plan that was in effect on April 15, 1997. Funds from the CHIP also may be used for providing medical assistanee to children during a presumptive eligibility period for Medicaid. This is one of several options for states to select for providing health care coverage for more children, as prescribed within the BBA's Title XXI program. Alabama was the first state to implement CHIP--just six months after the federal legislation was passed. Phase I was an extension of Mediciad. Phase II, also known as ALLKids, serves up to 200 percent of poverty.

Scope of Medicaid services

Title XIX of the Social Security Act (the Medicaid program) allows considerable flexibility within the states' Medicaid plans. However, some federal requirements are mandatory if federal matching funds are to be received. A state's Medicaid program *must* offer medical assistance for certain *basic* services to most categorically needy populations. All states, however, must cover these basic services: inpatient and outpatient hospital services; laboratory and X-ray services; skilled nursing and home health services; doctor's services; family planning; and periodic health checkups, diagnosis and treatment for children. States also may receive federal matching funds for providing certain optional services including: prescribed drugs and prosthetic devices; optometrist services and eyeglasses; nursing facility serviees for children under age 21; and home and community-based care to eertain persons with

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Medicaid ready to work with physicians, prepared for future

Editors of *MASA Review* had an opportunity to speak with John Searcy, MD, medical director for the State Medicaid Program. Here's what he had to say:

Q: Medicaid has initiated several managed care programs in the last few years. What do you see as the future of Medicaid managed care in the next three to five years?

A: We expect continued growth and maturity of the Patient 1st program. All counties are now enrolled, and we must now focus on educating our patients on how to properly use the care available to them. For the first time, most of our patients have a medical home. Patients now need to understand their responsibilities: to make and keep appointments; follow treatment plans; call their primary physician when they have concerns; and to respect their physician and the physician's staff.

Q: How is Medicaid monitoring managed care programs to ensure that the quality of patient care is not suffering?

A:We will continue to seek input from our Physician's Advisory Council for Patient 1st and the physicians caring for our patients. We are also developing surveys for patients and physicians. The actual monitoring of Patient 1st is shared within several units within the Agency using protocols developed jointly. Reports will be available to providers to allow them to compare their patient use patterns to others. We will monitor the Maternity Care Program to ensure appropriate delivering provider panel sizes; appropriate access to local providers; availability of case management services; as well as access to timely appointments. We also work with AQAF to monitor the HMO Plan (BAY Health) in Mobile County.

Q:What do you see as the greatest challenges facing the Medicaid program today?

A:Consistent funding of the Medicaid program in Alabama is our number one challenge. Consistency is essential if we wish to effect the long-term health needs of our patients. We know that the demographics of our patients will change dramatically as more of our patients will be over age 65. An older population will need more services per patient while the number of wage earners will decrease.

Q: What are you doing to deal with these challenges?

A:We hope funds made available through the tobacco settlement and other sources will provide a stable base by which we may improve our reimbursement rates in a manner that we can sustain. We hope that our managed care and disease state management initiatives will encourage new physicians to care for our patients. We want physicians who can help maximize the effectiveness of the care our patients receive to be able and willing to participate in Medicaid. We also hope to be closely involved in establishing a task force to address long-term care changes needed to meet the needs of our aging population.

Q: How can the physician community support the Agency's efforts?

A: Be involved. Give us feedback on the program and our initiatives. We want to improve the Medicaid program and the care our patients receive, but we need you to work with us. Physicians can provide input through Medicaid task forces and advisory groups. They can give us an opportunity to meet with their associations and staffs whenever possible so that we may present our plans and receive feedback. Most of all, they can keep the needs of our patients in the public eye, assuring that the needs of the patient are known.

Q: What do you see as the most serious issue facing Medicaid in the next five to ten years?

A: The dramatic increase in the aged population with its greater needs for health care services. We can anticipate increased utilization of medications, physician services, medical equipment, home health and other environmental support. The need for long term care for patients who lack support at home will place tremendous demands on our system and will require availability of new options to our present system. Unless we change the way we care for older citizens, we will not be able to afford the cost of this care.

In the shorter term, the increasing cost of prescription medications and the introduction of very specialized and costly medications, coupled with direct-to-consumer promotion of these products, threatens our ability to continue to pay for our prescription drug program.

Q: What changes in the program do you think will be necessary to deal with this pending crisis?

A:We must begin now to teach and encourage our citizens to plan for their needs. Retirement planning, including long-term care insurance can effect the utilization of our resources more than any system change which addresses best placement of patients. We must begin now to seek increased options for patients to choose when they must ask for assistance in their own daily care. We must begin now to understand what these patients need and want and build the coalitions necessary to make these options available in Alabama. We must educate physicians and other prescribers about the best use of medications, seek best prices from manufacturers and help practitioners by aiding in the management of abusive and difficult patients.

Our patient population will increase in average age dramatically. By the year 2025, 21 percent of our patients will be over age 65, compared to 13 percent today. This means that more than one million people in Alabama will be over age 65.

Q: Medicaid has seen a major shift in the last decade from being a "welfare" based program to being a broad-based program for uninsured women and children and for the disabled and elderly. What efforts are you taking to reach out to these populations to enroll them in the Medicaid program and protect their continued eligibility?

A: Last year we began 12 month guaranteed eligibility for children. Any physician's office interested in helping patients can assist in the enrollment process by helping applicants complete forms and encouraging submission of required documentation such as age and wage certification. In the future, we will include recertification in the monthly listing of patients in each Patient 1st panel to allow each office to be aware of these dates. The joint Medicaid/ALL Kids application is being revised to make it more user-friendly. A Robert Woods' Johnson Foundation Covering Kids Grant will allow us to pilot enrollment simplification and outreach projects in Washington, Coosa and Jefferson counties. Success could lead to statewide replication.

Q: Where do you see the composition of the Medicaid population moving to in the next five to ten years?

A: Our patient population will increase in average age dramatically. By the year 2025, 21 percent of our patients will be over age 65, compared to 13 percent today. This means that more than one million people in Alabama will be over age 65.

Q: There has been a lot of publicity at the national level about fraud and abuse in the Medicare and Medicaid programs. How prevalent are fraud and abuse in Alabama's Medicaid program, and what efforts are being made to prevent and/or identify fraud and abuse?

A: We do not feel that these issues are as prevalent in Alabama as in many other states. We do recognize that coding errors do occur, usually unintentionally.

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Q&A, continued from page 7

Our Program Integrity Division works with other states and uses techniques to more accurately understand the extent of any such problems. We recognize that fighting fraud and abuse helps our patients find appropriate care and uses our financial resources to their best advantage. Our new MMIS will include a claim check system to address inappropriate coding. In October 1999 we will install an enhanced System Utilization Review system to improve our surveillance abilities. The director of our Program Integrity division serves on two subeommittees of the federal Fraud and Abuse Technical Assistance Group (TAG). This keeps us in touch with the most current information being discussed. We maintain a close working relationship with the State Attorney General's Medicaid Fraud Unit and the Board of Medical Examiners.

Q: The Agency has talked about Disease State Management in the past. How does the Agency view the role of Disease Management and what plans does the Agency have?

A: We must address the long-term needs of patients with chronic illness. Disease State Management can aid us in this endeavor. Physicians wish to practice preventive care, not simply acute care of illness. The Agency can be an effective partner by helping identify patients with chronic illnesses and supplying these patients with material consistent with the physician's goals. Case managers who assist physicians by coordinating transportation, reminding patients of follow-up visits and reinforcing physician instructions will improve the maintenance of care needed for these patients. Newsletters to physicians and patients presenting information concerning approaches to disease care can be made available also.

We view disease management as a way to improve the quality of care to our patients and as a means to control costs through the provision of clinically appropriate care. The Agency plans to implement a focused initiative aimed initially at the appropriate management of asthma.

Q: The Agency has spoken about the cost of prescription drugs for several years. Do you feel the cost of prescription drugs is under control?

A: No. While we recently experienced a lower increase in prescription drug costs last year, we continue to experience an increasing cost per prescription and per patient. We must work together with our physicians to seek the most appropriate, cost-effective medieations for our patients.

Q: Medicaid has struggled throughout its existence to fund its programs, going from crisis to crisis. Do you anticipate any change to this situation, and what can MASA do to support adequate funding for the program?

A: The funds available through the tobacco settlement will provide immediate relief of many of our financial concerns. The professional associations including MASA, which supported allocation of these funds, facilitated a step in the right direction. Prudent use of these funds will remain necessary if we are to prepare for the increasing numbers of elderly we anticipate. We must work with all associations to plan comprehensive solutions, not solutions limited to benefiting only a few. ★

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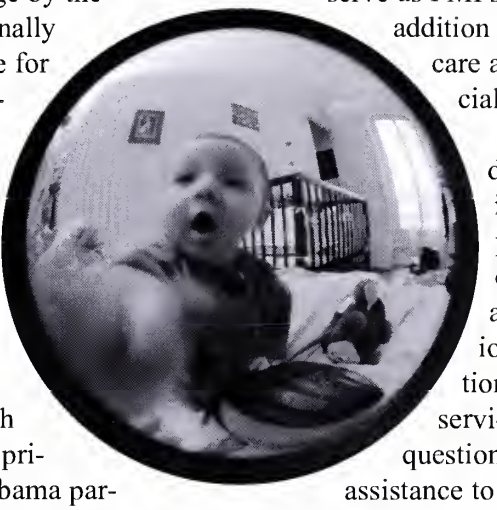
Patient 1st program provides 'medical home'

by Robin Rawls, Alabama Medicaid

Patient 1st is a primary care case management program begun in 1997 and was designed to provide Medicaid patients with a "medical home." In the past, patients who received their health care through coverage by the Alabama Medicaid program have traditionally held a card declaring that they are eligible for Medicaid but were left in search of physicians to care for them. As a result, patients often searched for solutions to their needs in emergency rooms, primary care offices and specialist offices without a clear understanding of the best way to receive long term help.



Now in its third year of operation, Patient 1st is assisting some 300,000 Alabamians get the care they need through more than 1,100 physicians who serve as primary care providers. Every county in Alabama participates in the program with the exception of Mobile County which participates in the BAY Health Plan.

Patient 1st provides a medical home for patients and allows their primary medical provider physician to manage their health care and coordinate the services to best meet their patients' needs. Basically, the program provides for assignment of eligible patients to a primary medical provider (PMP) physician. Each PMP agrees to provide 24 hour, seven day per week care support to the patient, to utilize the Preferred Drug List when appropriate, to authorize referrals to specialists and other providers, to ensure immunizations appropriate for age and to perform or designate an organization to perform EPSDT well care screens.

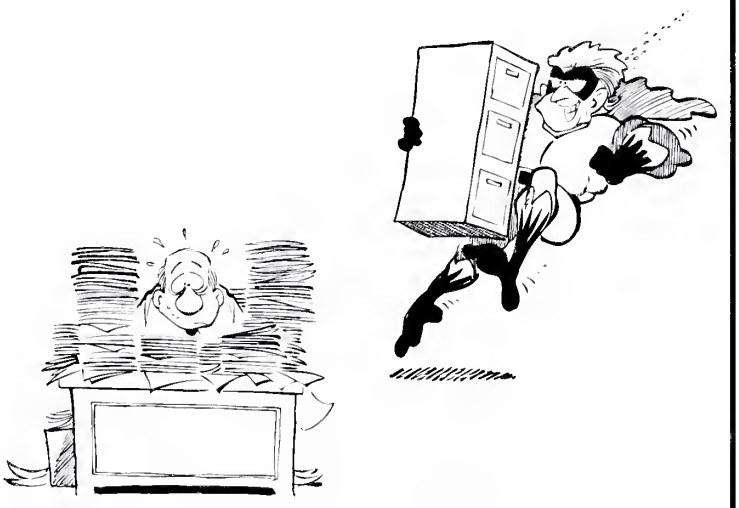
Patient 1st is designed to improve access to care, to enhance the physician/patient relationship by creating a medical home and to reduce costs associated with unnecessary or inappropriate use of medical services. One of the more significant trends of the program is an increase in the number of primary care physicians participating in the Medicaid program. Each physician can limit his or her caseload to as few as 25 patients or can accept 1,200 or more patients. This flexibility in caseload limits has encouraged more physicians to participate in Patient 1st.

Through this program virtually all Medicaid recipients now have a primary medical provider (PMP), known to the patient as a personal doctor and that they do not have to look upon the emergency room as a source for primary care. Primary care physicians who participate in Patient 1st are general practitioners, family practitioners, pediatricians, OB/GYNs and internists who provide primary care services. In addition, other providers may be assigned to patients with special needs on a case-by-case basis. Physicians who agree to serve as PMPs are paid a case management fee in addition to fee for service reimbursement for care actually provided. PMPs refer for specialty care as needed.

To support physicians, Medicaid has developed a variety of materials to aid in patient education about the appropriate use of the emergency room, obtaining referrals and keeping appointments as well as proper behavior in the physician's office. In addition, Medicaid has provided a customer service unit which assists with physician questions and coneerns as well as provides assistance to Patient 1st participants.★

Looks like you need The Office Assistant!

Call Valerie Sharp at (205) 426-0169 today!



The Office Assistant
P.O. Box 28607 • Birmingham, AL 35228

Medicaid: What can be done?

Physicians give their perspective of the challenges facing Alabama's Medicaid System

Medieaid is a large program that comes with big challenges—challenges that may threaten its very existence.

Adequate funding and access to care have been named the top problems according to many Alabama physicians who work with the Medicaid program. In Alabama, for example, Medicaid spent more than $2.43 billion in 1998, but not everyone who is eligible for Medicaid has been identified or served.

"It's been a recurrent theme—how do you fund it, especially for children?" said Billy Sellers, MD, a pediatrician practicing in Alexander City and a member of the Medieaid Physician Advisory Committee. "The state must develop some ongoing, reasonable and consistent funding source. The tobacco settlement is not a permanent fix. Solutions have got to be found."

Reimbursement: the real can of worms

Not enough physicians accept Medicaid so it is hard for recipients to find someone who can see them. That concern, however, can be directly related to the poor reimbursement Medicaid provides physicians.

"Reimbursement needs to be brought closer to the private insurance level. If the ultimate goal is to provide care, then you must have the providers. Our practice experiences about a 25 to 40 percent reimbursement rate from Medicaid. Our costs for overhead, however, normally are 50 to 55 percent. It doesn't take much math to figure out that we have a loss when we see a Medicaid patient. Reimbursement is so poor that many physicians don't want to see a Medicaid patient because they can't keep their doors open for business. The higher number of Medicaid patients you have, the worse your bottom line looks," Dr. Sellers said.

Robert H. Story, MD of Tuskegee and another member of the Medicaid Physician Advisory Committee agreed, "A lot of physicians don't even bother filing the charges with Medicaid because it is not even worth it. The reimbursement is not enough to warrant all the paperwork."

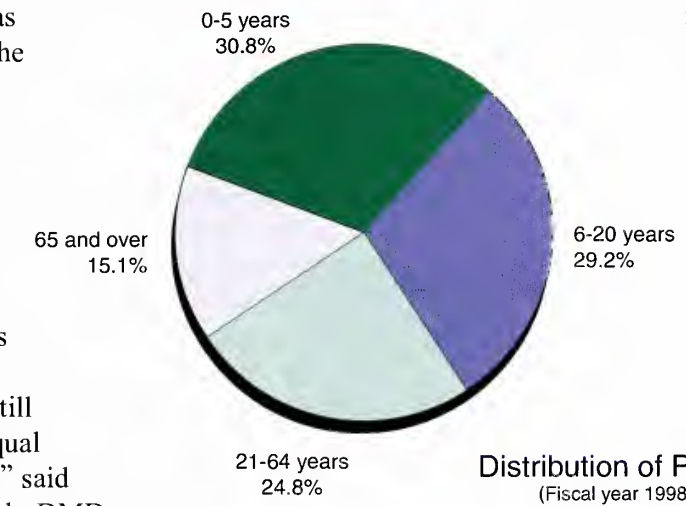
Even if the Medicaid reimbursement rate can be brought up the same level as ALL Kids, the children's private insurance program sponsored by the state, more physicians would be interested in adding Medicaid patients to their practices, added Marsha Raulerson, a Brewton pediatrieian who also serves on the Physician Advisory Committee.

There's also a hassle factor to consider. "Too many times you file and don't get paid. Medicaid only pays for 14 doctor visits per year, so the rest of the year you may have to treat the patient for free. Someone who is acutely ill could use all their visits relatively quickly, there's no leeway for that with Medicaid," Dr. Story said. "Providing prescription medication is also a problem."

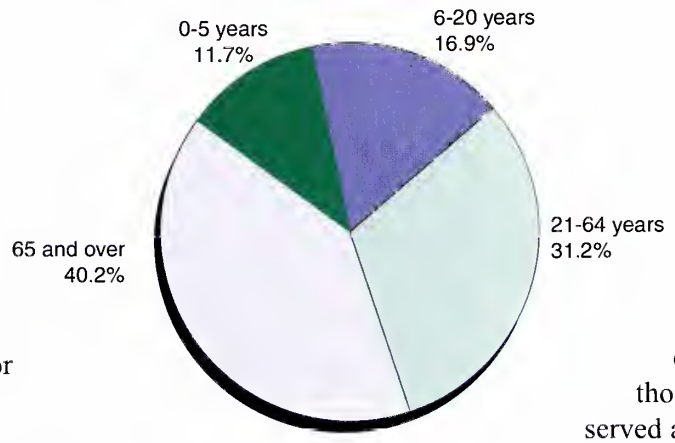
Dental care reimbursement is worse.

"A dental focus group was appointed in 1997 and worked for more than a year making recommendations for improvements to the dental Medicaid program. Most of these recommendations have been implemented and a small fee increase was effected. However, the amount was so small that the large number of dentists who must come into the program in order to provide the necessary care has not occurred. Our children still do not have equal access to care," said Frederick Smith, DMD, a Birmingham dentist who also serves on the Medicaid Physician Advisory Committee. "The availability of dentists who accept Medicaid eligible patients is so sparse that many patient's parents seek care only for the most painful conditions. Often multiple visits are necessary to first control infection and subsequently treat the dental disease. Preventive dental care is not provided at an effective level for these children."

Composition of Eligibles
(Fiscal year 1998) source: Medicaid



Distribution of Payments by Age
(Fiscal year 1998) source: Medicaid



Funding: who controls the money?

Many believe that the funding solutions must come from the political leadership of the state.

"Over the 25 years I have been associated with the program there has never been the political will to provide adequate dental health care for the Medicaid eligible children of this state," Dr. Smith said.

Dr. Sellers agreed, "It's been a smoke-and-mirrors form of funding for Medieaid for years. The state doesn't value the service politically. More than one politician has said that Medicaid recipients don't vote. The people of this state have not taken a stand on the issue and forced the politicians to address the problem."

In addition, children are competing against the elderly as far as funding is concerned. Caring for the elderly consists of 33 percent of expenditures for Medicaid, however, only 14 percent of those served are the elderly. On the other hand, 54 percent of the children under six are Medicaid patients.

One suggestion was to raise public awareness to create the demand on politicians to fix the ailing system.

"I would probably get fired if I was the Medicaid commissioner because I would be on television telling everyone that children are suffering because the state isn't giving enough money to Medicaid to provide the care the children need," Dr. Story said. "The tobaceo money is definitely inadequate—Medicaid still won't get as much as it needs. No governor has ever given enough money to Medicaid. Unless we convince the public that this is an issue, it is not hot enough for the Legislators or the Governor to deal with at all."

The hope with the new administration is that Governor Siegelman who has publicly voiced his support for children and children's issues—going so far as to appoint the state's first commissioner dedicated solely to children's issues—will address the problem.

Medicaid and its challenges

In the meantime, Medicaid faces the challenge of ensuring that children who qualify for Medicaid are enrolled and that those enrolled can be served adequately.

"We must develop outreach efforts to identify those who qualify for Medicaid and get their health care needs met," Dr. Raulerson said. "If Medicaid incorporated the same public awareness techniques ALL Kids used, they could find the people that are Medicaid eligible very quickly."

Posters in every physician and hospital waiting room along with pre-addressed pre-stamped applications to every public school child in Alabama were effective in identifying thousands of children who were eligible either for Medicaid or ALL Kids, she added.

"Having a method that hospital or physician staff can instantly sign a patient up for Medicaid would be another viable solution," Dr. Raulerson said. "That way when a person comes in for care and they have no insurance but are Medicaid eligible, they can be signed up for services while in the hospital or physician's office."

Allowing physicians to have access to Medicaid

(continued on page 20)

chronic impairments.

Within broad federal guidelines and certain limitations, states determine the amount and duration of services offered under their Medicaid programs. States may limit, for example, the number of days of hospital care or the number of physician visits covered. Alabama limits physician visits to 14 per year. Two restrictions apply: (1) limits must result in a sufficient level of services to reasonably achieve the purpose of the benefits; and (2) limits on benefits may not discriminate among beneficiaries based on medical diagnosis or condition.

In general, states are required to provide Medicaid coverage for comparable amounts, duration and scope of services to all categorically-needy and categorically-related eligible persons. There are two important exceptions: 1) Medically necessary health care services identified under the EPSDT program for eligible children which are within the scope of mandatory or optional services under federal law, must be covered even if those services are not included as part of the covered services in that state's plan (i.e., only these specific children might receive that specific service); and 2) states may request "waivers" to pay for otherwise-uncovered home and community-based services (HCBS) for Medicaid-eligible persons who might otherwise be institutionalized (i.e., only persons so designated might receive HCBS). States have few limitations on the services which may be covered under such waivers as long as the services are cost effective (except that, other than as a part of respite care, they may not provide room and board for such recipients). With certain exceptions, a state's Medicaid Plan must allow recipients to have some informed choices among participating providers of health care, and to receive quality care that is appropriate and timely.

Long term care is an important and increasingly utilized provision of Medicaid—especially as our nation's population ages. Almost 45 percent of the total cost of care for persons using nursing facility or home health services in the U.S. in recent years is paid for by the Medicaid program.

Medicaid trends

Medicaid was initially formulated as a medical care extension of federally-funded programs providing cash income assistance for the poor, with an emphasis on dependent children and their mothers, the disabled and the elderly. Over the years, however, Medicaid eligibility has been incrementally expanded beyond its original ties with eligibility for cash programs. Legislation in the late 1980s assured Medicaid coverage to an expanded number of low-income pregnant women, poor children and to some Medieare beneficiaries who are not eligible for any cash assistance program. Legislative changes also focused on increased access, better quality of care, specific benefits, enhanced outreach programs and fewer limits on services.

Since its inception, Medicaid has had very rapid growth in expenditures. Although the rate of increase has subsided recently, acceleration over the years has been noteworthy. This rapid growth in Medicaid expenditures has been due to several factors. The primary ones include:

- expanded coverage and utilization of services and the increase in the size of the Medicaid-covered populations (a result of federal mandates, of population growth, and of the earlier economic recession);
- the disproportionate share hospital (DSH) payment program, coupled with provider tax and donations programs;
- the increase in the numbers of very old and disabled persons requiring extensive acute and/or long term health care and various related services;
- the results of technological advances to keep more very low birth-weight babies and other critically ill or severely injured persons alive and in need of continued extensive and very expensive care; and
- increased payment rates to providers of health care services, when compared to general inflation. In Alabama. this issue is being addressed currently.

As with all health insurance programs, most Medicaid recipients require relatively small average expenditures per person each year. Providing health care coverage for almost 17 million children, who otherwise would usually receive little or no medical care, is and has always been a primary concern of the Medicaid program. Yet the data for 1996 indicate that Medicaid payments for services for these children averaged only a little over $1,000 per child. There are, however, certain other specific groups for whom Medicaid is at least as essential: those comprising far fewer persons, but ones who have much larger per-person expenditures. Regardless of their initial financial situation, their medical needs are so great and/or continuous that most of these patients must eventually depend upon Medicaid. When expenditures for these high and

(continued on page 13)

Medicaid, con't from page 12

lower cost recipients are combined, the 1996 payments to health care vendors for over 36 million Medicaid recipients average $3,400 per person.

Long term care is an important and increasingly utilized provision of Medicaid—especially as our nation's population ages. Almost 45 percent of the total cost of care for persons using nursing facility or home health services in the U.S. in recent years is paid for by the Medicaid program. A much larger percentage is paid for by Medicaid, however, for those persons who use more than four months of such long-term care. As Medicaid has continued to provide extensive nursing facility care over the years, the focus has become the struggle to rely more on community-based long term care alternatives. The data for 1996 show that Medicaid payments for nursing facility (excluding ICF/MRs) and home health care totaled $40.5 billion for more than 3.6 million recipients of these services—an average 1996 expenditure of more than $12,300 per long-term care recipient. With the percentage of our population who are elderly and/or disabled increasing faster than the younger groups, the need for long term care is expected to increase.

Another significant development in Medicaid is the growth in managed care as an alternative service delivery concept different from the traditional fee-for-service system. Under managed care systems, health maintenance organizations (HMOs), prepaid health plans (PHPs) or comparable entities agree to provide a specific set of services to Medicaid enrollees, usually in return for a predetermined periodic payments per enrollee. Managed care programs seek to enhance access to quality care in a cost-effective manner. Waivers may provide the states with greater flexibility in the design and implementation of their Medicaid programs. The Balanced Budget Act of 1997 provided states a new option to use managed care. Medicaid managed care programs, such as BAY Health and Patient 1st in Alabama, are growing rapidly. The number of Medicaid beneficiaries who are now enrolled in some managed care program continues to increase, and may soon approach 50 percent of all Medicaid enrollees. Several states have converted their entire Medicaid programs into managed care.★

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APN 25-901-0022

Medicaid's prescription drug program initiatives

by Robin Rawls
Medicaid

Prompted by escalating costs of single source legend drugs and the formulary expansion required by the 1990 Omnibus Budget Reconciliation Act (OBRA), the Alabama Medicaid Agency's Pharmacy Program has implemented a comprehensive program to maximize funds available for drug benefits while assuring appropriate and effective pharmacy care.

With the end of the Medicaid formulary in the early 1990s, Medicaid's prescription drug program grew dramatically, requiring an increasingly larger portion of the Medicaid budget. Watching drug costs escalate from approximately $60 million in 1990 to more than $200 million in fiscal year 1998, Medicaid officials turned to MASA and the state's pharmacy associations for help in developing a solution.

Already in place, the Drug Utilization Review (DUR) board, whose physician members are nominated by MASA and the Alabama Pharmacy Association, took an active role in shaping the Medicaid initiatives now in place today. Members of the Pharmacy & Therapeutics (P&T) Committee, composed of five practicing physicians and three active pharmacists, likewise have helped the Medicaid Pharmacy Program to make significant progress toward achieving those goals.

The early results are promising. Alabama Medicaid's Pharmacy Program costs increased by six percent in fiscal year 1998, the lowest rate of growth in more than 14 years. This lower-than-expected growth rate represented program savings of approximately $13 million (total state and federal funds) and put Alabama in second place behind the state of Michigan, which had a four percent growth rate.

Medicaid has sought to address pharmacy issues through the implementation of various programs, including:

- Coverage for over-the-counter medications,
- A state Maximum Allowable Cost (MAC) program,
- Programs designed to foster safe, appropriate and effective drug therapy, such as retrospective Drug Utilization Review (DUR), prospective DUR, Medicaid Preferred Drug Program, provider education, and expanded prior authorization
- Pharmacy Claims Editing
- Case Management

The Agency has been able to aggressively expand these initiatives with the clinical and administrative support of the Alabama Quality Assurance Foundation (AQAF) and the Samford School of Pharmacy which administers the program under contract.

Pharmacy Claims Editing Program Enhancements

Monthly Dosage Limits

In an effort to foster appropriate drug utilization, Medicaid, upon the recommendation of the P&T Committee, expanded the maximum monthly dosage units for various drugs to include analgesics, muscle relaxers, and atypical antipsychotics. Maximum units are established as monthly limits (30 days) although the Medicaid Help Desk can override the limits in certain situations when a supporting diagnosis and justification are provided.

Prior Authorization

In the spring of 1996, the Medicaid Agency, with the support of MASA, established the present Prior Authorization program. Based on decisions made by members of the P&T Committee, a limited number of brand name drugs now require prior authorization. The prescribing physicians or the dispensing pharmacy must receive approval for brand name drugs in classes placed under prior authorization before Medicaid will make payment. This may be required for drugs when clinical literature indicates that generic and over-the-counter alternatives are therapeutically equivalent to expensive brand name drugs, or when there are documented misuse and/or abuse considerations. Prior authorization currently represents approximately $10 million in annual savings. Safeguards to protect the integrity of the process and the maintenance of quality of care have been established as well.

(continued on page 15)

Case Management

This program identifies patients with apparent drug utilization concerns such as patients with multiple prescriptions for controlled substances and/or use of multiple physicians and pharmacies. This is a hands-on program where AQAF nurses develop plans of care and make efforts to coordinate care with the patient, physician and pharmacy. In many cases, the case managers have been able to assist the patient in understanding the need for a primary care doctor, as well as making the prescribing physician aware of utilization trends and patterns that are not in the best interest of the patient.

Maximum Allowable Cost (MAC) Program

This program is designed to encourage appropriate generic and over-the-counter substitution when therapeutic equivalency exists between the brand and generic products. The Agency strives to assure products are equivalent and available to Alabama providers at or below the established MAC price.

Provider Education

This program is designed to educate prescribers in the state on the availability of generic and covered over-the-counter alternatives, as well as use and understanding of the Medicaid Preferred Drug List, approved by the P & T Committee. This program includes on-site visits by clinical pharmacists, letter interventions, provider report carding and newsletters.

Drug Utilization Review

Drug Utilization Review (DUR) is an administrative process of utilization review and quality assessment. Required by the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), the Medicaid DUR Program consists of a retrospective review system, educational interventions, and an on-line prospective review program.

Retrospective DUR

This program is designed to identify trends in inappropriate prescribing and dispensing and to develop and initiate effective educational interventions. Retrospective DUR is required under federal law and has proven to be an effective means of identifying problem areas for education and program changes.

Prospective DUR

Prospective DUR is an on-line program that alerts pharmacists to potential drug therapy concerns before the prescription is delivered to the patient. Alerts are given to pharmacists in the areas of early refill, therapeutic duplication, drug-drug interaction, high dose and preferred drug product selection.

Help Desk

Through clinical and administrative support offered by the Medicaid help desk, the Agency has been able to carefully expand initiatives to manage the increasing costs associated with providing pharmacy benefits.

Supported by three clinical pharmacists and a physician, the help desk has allowed Medicaid to implement computer safeguards in the on-line Drug Utilization Review Program to systematically edit for abuse and inappropriate use through early refills, drug interactions and excessive quantities. At the same time, the Medicaid help desk is available to review and consider requests for overrides. The help desk is staffed seven (7) days a week, Monday-Friday, 8 a.m. – 6 p.m. and Saturday–Sunday, 10 a.m. – 4 p.m.★

President's message, con't from page 2

for every dollar the state allots. Additionally, children cost only approximately $1,000 a year as opposed to the elderly who cost approximately $8,800/ year and the disabled at $9,500/year per beneficiary. Our children need access to medical care and, if adequately funded, this program goes a long way toward providing it.

Where and how does Medicaid spend its money? By federal law, states must cover inpatient and outpatient hospital services; care provided by physicians, midwives, and certified nurse practitioners; laboratory and radiographic services; nursing home care and home health care; early and periodic screening, diagnosis, and treatment (EPSDT) for persons under 21 years of age; family planning; and care provided by rural health clinics and federally qualified community health centers. It also acts as payer of premiums and cost-sharing for supplementary insurance for low income Medicare beneficiaries as well as provider of prescription drugs for this population. Additionally, state law mandates a set payment for nursing homes.

In 1998, Medicaid had $2.43 billion in revenue, $1.68 billion from federal matching funds, with over $448 million of the state funds coming from public hospital transfers and the Alabama Health Care Trust Fund, sources that are rapidly drying up. Expenditures included 39 percent to hospitals, 22 percent to nursing homes, 9 percent to mental health, 8 percent to drugs, 6.5 percent to physicians, and 2.5 percent on administrative costs with the remainder spent on the other previously mentioned services. Although physicians control the majority of Medicaid care, and hence expenditures, only a small portion trickles down to physicians. A handful of selected drugs costs Medicaid more than all spending on physicians' care of children. The shameful coverage eligibility requirements of the indigent population combined with inadequate funding of those covered causes a serious problem of access to care. The entire problem is caused by insufficient funding of Medicaid.

In 1998, Medicaid had $2.43 billion in revenue, $1.68 billion from federal matching funds, with over $448 million of the state funds coming from public hospital transfers and the Alabama Health Care Trust Fund, sources that are rapidly drying up.

What can physicians do? First, educate yourself about the system. If you are a Patient First primary care physician, you must get to know your patients, many of whom were assigned to you without your knowledge. You must also know the rules. You are required to authorize every visit to a specialist you deem necessary. You must be available to your Medicaid population 24 hours a day. You cannot turn on your answering machine after hours and tell your patients to go to the Emergency Room. Finally, be cost conscious about your prescribing. If an inexpensive generic drug will do the job, then choose it over a more expensive brand name drug. Except for drug classes which require pre-authorization, Medicaid is required to pay full price for whatever you write on the prescription. By taking these steps, we may be able to save Medicaid money, possibly allowing a more generous eligibility cap, or better payment for the various codes.

What is MASA doing? For starters, we are gathering the leaders of the primary care specialty societies to help educate their members on the proper usage of the Patient First program, and to sort out problems between primary care and emergency physicians caused by the system. We are forming a coalition of advocacy groups and the core group mentioned earlier which will create a strategy to assure access through continued and improved funding of CHIP, and stable and improved funding of Medicaid in general. This will include lobbying the legislature and the governor, who has proclaimed children to be a top priority of his administration. Additionally, there may be a media campaign which will highlight the severity of the funding problem. We will continue to urge the agency to increase its level of eligibility to include the 78 percent of adults who live under the poverty level but are currently ineligible for Medicaid. We will also continue to urge the agency to increase its payment to physicians so its reimbursement for various codes at least matches Medicare.

Even if some of these steps are taken Medicaid will need much better funding than it currently enjoys, so we will continue to lobby the legislature for appropriate funding for all of Medicaid, something the agency itself has not done.

Unfortunately, with the loss of the franchise tax money and due to the low tax structure in our state, increased funding will be difficult without increasing taxes or changing government funding priorities--even with the money from the tobacco settlement.

Certainly, we would like to see all of the above happen. As it is, we will probably be in a long line queuing up for a meager handout, as our patients continue to suffer from lack of access to care. We must, however, continue to fight for reasonable and appropriate care for these patients and reasonable and appropriate compensation for their care.★

Executive director, con't from page 2

attention as current funding sources disappear—including that of the tobacco settlement. The Medical Association congratulates the Legislature and the Governor for their leadership and willingness to take the first step to ensure that Alabama's children have access to healthcare.

Our children are our future. The Medical Association of the State of Alabama has been accused wrongly of trying to "steal" money away from disenfranchised children. Our association wants to ensure that our children have access to high quality medical care. Providing for Medicaid funding with a portion of the tobacco settlement monies is an appropriate, though partial, solution.★

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GROUP PURCHASING PROGRAM

In cooperation with the Southern Medical Association, MASA offers a Group Purchasing Program to members interested in buying name-brand products at a discount. Members who enroll receive a monthly buyers "Showcase" which illustrates products for both the home and the office, everything from electronic equipment to CPT coding books. Included as an Auto Pricing Service which will provide you with the list price versus the actual dealer cost on the automobile of your choice. MASA members may join the Group Purchasing Program for a nominal fee of $25. *Contact: Group Purchasing Program at 1-888-223-6654*

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One of the biggest problems for physicians is collecting fees owed to them by patients. Keeping costs down and cash flowing are critical factors in the success of any practice—fiscal soundness is a must, and physicians need an effective collection agency to assist them in recovering delinquent aecounts such as I.C. Systems, Ine. *Contact: I.C. Systems, Inc. 1-800-685-0595*

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Coverage is available through Mutual Assurance, Inc. of Birmingham, the largest writer of liability insurance for physicians in the state. Mutual Assurance was formed by MASA during the insurance crisis of the mid 1970's, when liability coverage was suddenly not available to Alabama physicians. Mutual Assurance, Inc. also offers other types of insurance coverage such as disability, life, business overhead. *Contact: Mutual Assurance, Inc. 1-800-282-6242*

HEALTH INSURANCE COVERAGE

MASA endorses Blue Cross Blue Shield group health insurance plans for you and your staff.
Contact: Emmett Wyatt, MASA 1-800-239-6272

PRACTICE MANAGEMENT RESOURCES

United Communications Group offers newsletters and other publications to help physicians, including: Part B News, Part B Answer Book, Practice Strategies for Managed Care, Physician Practice Coder, RBRVS FeeCalc software, Medicare Compliance Alert and Physician Office Lab News. Exclusive MASA discount available. *Contact: United Communication Group, 1-800-929-4824, Ext. 2238*

Medicaid implementing new computer system

Improvements in eligibility verification and on-line claims submissions will be among the many proposed benefits to physicians when the Alabama Medicaid Agency's new Medicaid Management Information System (AMMIS) becomes operational on October 1. These benefits include:

- Easier method of verifying eligibility
- More information provided up-front to physicians
- Streamlined process for on-line claims submission
- Automated Voice Response System (AVRS) will feature fax-back system to print an eligibility verification via fax machine
- Claims submission process will provide quicker turnaround on error messages
- Increased number of provider representatives
- Increased number of telephone lines for easier access
- Standardization of the prior authorization process

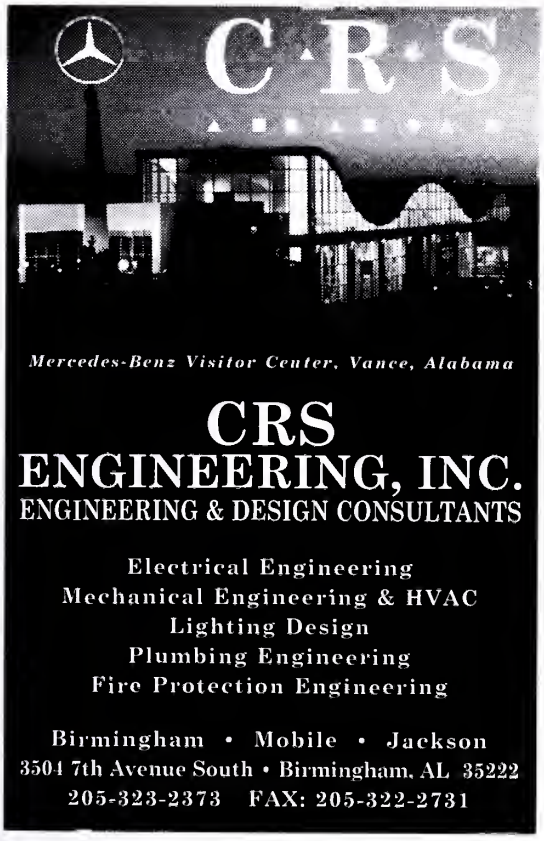
New Software for Claims Submission

The new system will provide several new benefits. For physicians who currently use the PC-MACSAS and NECS software, EDS will supply software that will run in a Windows environment. The new PC software should be mailed by August 15. For those physicians who use a third party for claims submissions and/or software, the original vendor specifications were mailed on March 15 and revisions were sent on June 1.

In order to have faster claims processing, EDS, Medicaid's fiscal agent, will provide Prior Authorization (PA) and Long Term Care (LTC) Application software in December 1999. Vendor specifications for both the PA and LTC electronic submissions already have been distributed.

All third party vendors will be required to test their electronic claims submissions prior to October 1. Claims are to be submitted to the old AMMIS through September 30. EDS will still accept paper claims for those not using the updated software although claims will need to be on approved claims forms in order to be scanned into the new system. Because of the benefits to providers associated with electronic claims, Medicaid is encouraging all providers to file claims electronically by the year 2000.

Providers with questions about the Electronic Claims Submission software or specifications, please call EDS at 1-800-456-1242. ★



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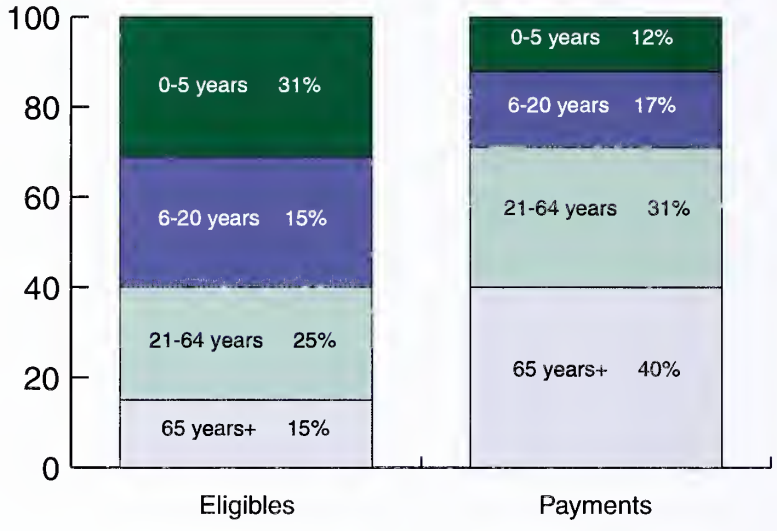
Doctors, con't from page 11

records so they can work with the patient to maintain their eligibility status is another solution, Dr. Raulerson said.

"A lot of times Medicaid will mail a letter to a patient to tell them it is time to renew their eligibility status for the program. The person doesn't always get the letter, but if they do, they may not understand what it means or they may be illiterate. Allowing a physician access to information like that will enable us to remind our patients to get their eligibility renewed," she said.

Comparison of Eligibles and Expenditures by Age
(Fiscal year 1998) source: Medicaid



Physicians should also be able to monitor how often their patients are being seen by other physicians as well as how often they are going to the emergency room for care rather than the physician's office who serves as their "medical home," Dr. Raulerson said. "This would also give us a report on how we are doing as physicians in providing care through the Patient 1st program."

Patient 1st was created to provide Medicaid recipients with a medical home and discourages Medicaid recipients from seeking care for non-emergencies at the local emergency room. Originally, the program allowed hospitals to turn away non-emergency cases, however, recent regulations from the federal government has changed the process. Now the decision of whether or not to go to the emergency room does not remain with the physician and the patient, but rather relies on a "prudent lay person" standard which allows the patient to decide for himself or herself whether or not to go to the emergency room.

In addition, missed appointments with physicians are a problem.

"Quite often this is related to transportation. A patient can't keep an appointment because they have no ride," Dr. Sellers said.

Rural patients often travel to large metropolitan areas in order to find a dentist or a physician, Dr. Smith said. "Driving distances of 50 or 100 miles are common and their transportation is unreliable," he said.

Not every aspect of Medicaid is awry, however.

Medicaid recipients receive good prenatal and pregnancy care, said Drs. Story and Raulerson.

"The infant mortality rate dropped as a result of the implementation of the Medicaid Waiver Program for Pregnant Women and Newborns," Dr. Raulerson said. "In addition, assigning the unborn baby a number when the mother signed up for care made it possible for the child to get care as soon as it was born."

Medicaid staff has also developed good relationships with physicians, she said.

"Many staff give physicians who have identified problems more than lip service; they try to find solutions," she added. "There is still work that needs to be done and the staff is willing to listen to the concerns physicians have. We need to bring our concerns to the table."★

Medicaid Patients
Alabama 1998

source: Medicaid

15.3%	of population
45%	of total births
54%	of the children under six years
72%	of nursing home patients
60%	female
45%	white

Q: I'm worried about taking the correct actions when releasing a patient's record. What guidelines should I abide by when releasing records to third parties to protect myself and my patient's confidentiality?

A: Medical professionals should consider general guidelines when releasing records. Never release information unless you have one of the following items: a patient's signed authorization, a subpoena or a court order.

If you're asked to produce a record and have the patient's consent, consider these guidelines to ensure you've taken proper action to cooperate while honoring your patient's privacy:

· Review the request for completeness and validity. Review the requested record for accuracy and completeness (If you have questions or concerns about releasing the information, contact the risk management experts at Medical Assurance for assistance).

· Copy only the requested parts of the record.

· Do not alter the record.

· Hand deliver the record and obtain a signed receipt for it, or send via registered mail, return receipt requested. Do not fax the record.

· Place a copy of the court order, subpoena or patient's authorization in the patient's file and document what records were sent and when.

Although all information in a patient's record is confidential, stricter rules apply for information courts consider "privileged," such as psychiatric/psychological, HIV or drug/alcohol treatment information. This information should be released only if you have the patient's specific authorization or a direct court order. A patient's general consent to release or a subpoena alone is insufficient for releasing such information. This is a tricky area within the law, and you may want to contact Medical Assurance for risk management guidance.

Remember, the releasing of any information should be thoroughly documented in the patient's record and all documents pertaining to the release should be included.

Physicians insured by Mutual Assurance, MASA's endorsed professional liability carrier, may contact the company's Risk Resource Center for answers to liability questions and/or risk management by calling (800)282-6242 or via email at rmhelp@maih.com.

Severity of Malpractice Verdicts at All Time High

Forty percent of all malpractice verdicts are now for $1 million or more, according to the latest research release by Jury Verdict Research of Solon, Ohio. Perhaps even more troubling is that the study shows the average award for malpractice jumped 10%, and the mean award for medical malpractice is now $2.2 million. These troubling statistics are even more sobering in light of a recent report from A. M. Best noting the number of failures by medical malpractice insurers in the past three years. Best concluded that underpricing was the chief cause of each malpractice insurers failure.

Insurance experts and medical/legal authorities urge MASA members to renew their focus on long-term commitment and stability when making their choice of a malpractice insurer. Experience has shown that no company can sell penthouse protection at bargain basement rates for long and still maintain their viability.

upcoming

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August 12-15
MASA Summer Regionals CME
Guntersville State Park
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August 17
Mutual Assurance 1999 Loss Prevention Seminar
Your Practice Prescription for the Future
Decatur
Contact: Gina Preston
(800) 282-6242 or (205) 877-4430
CME Credit: 2 hours Category 1

August 18
Internet Workshop for Physicians
University of South Alabama
Mobile
Contact: Judy Burnham
(334) 460-6888
CME Credit: 4 hours Category 1

August 22
Mutual Assurance 1999 Loss Prevention Seminar
Your Practice Prescription for the Future
Destin, Florida
Contact: Gina Preston
(800) 282-6242 or (205) 877-4430
CME Credit: 2 hours Category 1

August 27-28
4th Annual Managed Care Conference
New Orleans, Louisiana
Contact: Tina Long or Jessica Scott, SMA
(800) 423-4992
CME Credit: 13 hours Category 1

SEPTEMBER

September 24
Mutual Assurance 1999 Loss Prevention Seminar
Your Practice Prescription for the Future
Panama City, Florida
Contact: Gina Preston
(800) 282-6242 or (205) 877-4430
CME Credit: 2 hours Category 1

September 25-October 5
Galapogas Voyage—*Therapeutics Update*
Contact: Charlotte de Frances
UABSOM/International Expeditions
(800) 633-4734

September 30-October 1
Advances in Clinical Hepatology and Liver Transplantation
Birmingham
Contact: UAB Division of CME
(205) 934-2687
CME Credit: 7.5 hours of Category 1

September 30-October 3
17th Annual Rheumatology on the Beach
Destin, Florida
Contact: Annette Lee
(205) 877-1692
or David McLain, MD at dmclain@pol.net

events

OCTOBER

October 8
11th Annual Infectious Disease Conference
Huntsville
Contact: UAB CME Office
(256) 551-4490

October 10-13
Current Clinical Internal Medicine Seminar
Lake Buena Vista, Florida
Contact: George M. Converse, MD
(205) 783-5276
CME Credit: 15 hours Category 1

October 13-16
Pediatric Infectious Disease Seminar
Lake Buena Vista, Florida
Contact: George M. Converse, MD
(205) 783-5276
CME Credit: 15 hours Category 1

October 13
MASA Collections Seminar
Location TBA

October 14
MASA Collections Seminar
Birmingham

October 28-31
Internal Medicine Seminar
White Sulphur Springs, West Virginia
Contact: George M. Converse, MD
(205) 783-5276
CME Credit: 15 hours Category 1

October 29
7th Annual Shoals Cardiology
Florence
Contact: UAB CME Office
(256) 551-4490

DECEMBER

December 27, 1999-January 2, 2000
Belize Expedition—*The History & Future of Medicine*
Contact: Charlotte de Frances
UABSOM/International Expeditions
(800) 633-4734

Through These Eyes
My Ministry to the Mentally Ill
by Otis Daniel Thomas
The Best of Times
147 Corporate Way
Pelham, Alabama 35214 1996
202 pages

Reverend Thomas served as the first full time chaplain at Bryce Hospital. He describes the "privilege" to have worked with his "spiritual brothers and sisters." Prior to coming to Bryce, he had served 23 years as a local pastor and earned a master's degree in sociology. He served 14 years at Bryce. He was happily married for 65 years until the death of his beloved wife. He is now 100 years old and continues to preach each Sunday. Such is the depth of his commitment and persistence.

His stories are telling anecdotes of the mostly sad and abandoned souls he met at Bryce. He tells of the fearful shock treatments common at that time. He relates commitments with "no clear standards" and "no safe guards against false charges." People were committed "for custody and treatment." With "nearly 5,000 people" to care for, few medications, and a staff of "seven doctors, a superintendent and his assistant, one dentist, eight registered nurses," and one chaplain, treatment was diffused and limited. A single doctor might have as many as "900 patients." "The single dentist worked from dawn to dusk." One doctor told him that "when a doctor comes to work in a mental hospital, he stoops mighty low." Reverend Thomas saw it as a high calling.

Chaplain Thomas approached his work with great enthusiasm and a sense of wonder. He seems to have been equal parts counselor and preacher. He saw desperate situations and dealt with them as best he could. He was uniformly comforting, not at all judgmental. He possessed common sense in realizing the magnitude of the undertaking. He did not become grandiose. He knew limits. He observed boundaries. He was cautious but accepting of people, knowing he might never know the real truth of whether a person ought truly to be at Bryce or whether it was a "frame up," as one patient put it. He developed a "Golden Rule" for those with psychiatric illness; "Do unto the mentally ill as if tomorrow you will be in their place." Had this rule been in place in the past he believes that people with mental illness "would never have been taunted and teased, mimicked and mocked, flogged, thrown into dungeons and burned; nor would they have been neglected and forgotten by their relatives, the church, community, and state." He points out that "the fingers of circumstanee" can cause anyone to develop a mental illness.

This book is rich in many respects. It is an important history of mental illness in Alabama. His stories show the sad plight of people who were isolated and seen as outcasts. He reached out to these people both religiously and as a talented and compassionate psychotherapist to a flock/practice of 5,000, a monumental task. In all this he never loses his sense of humor or his courage. Lastly the book was written after his eyesight failed. Friends, fellow Methodists, editors, readers, including Virginia Caine, a mutual friend of mine and Reverend Thomas, who introduced the book to me and to whom I am grateful, assisted in the compilation of this book.

This is recommended to both physicians and general readers. It is a compelling tale of a brave man in a harsh world who seizes the opportunity to bless his fellow traveler. The reader will find it enriching and rewarding.

Chaplain Thomas, 100 years old on Dec. 3, 1998, welcomes your correspondence at Skyland Oaks Retirement Center, 5001 Old Montgomery Highway, Tuscaloosa, AL 35405.
Copies of this book are available, retail (for $12.95, including mailing costs) or wholesale from Al Thomas, 3440 Portsmouth Drive, Hoover, AL 35226; 205-824-2913.

Reviewed by David W. Hodo, MD
Book Editor

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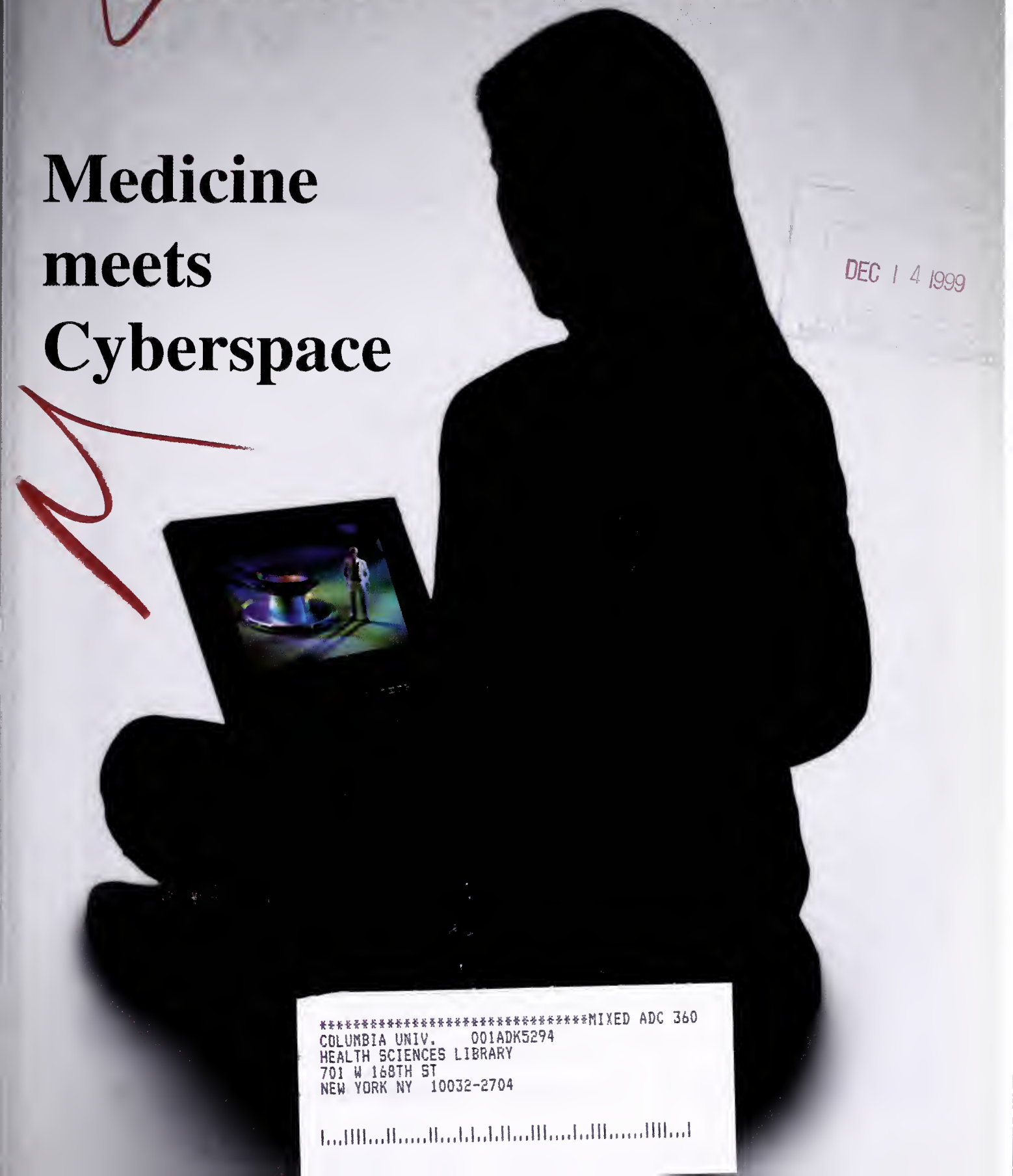
MASA REVIEW

Medicine meets Cyberspace



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MASA REVIEW

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Book Review Editor David W. Hodo, MD

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PRESIDENT'S MESSAGE

Do you know what a 'cobweb' is?

Ask a veteran web surfer (who may be only 14 or younger) and they can tell you--a "cobweb" is a website that never changes.

If you are a pre-Baby Boomer like me, learning the latest computer "lingo" has been like learning a foreign language--unlike our children who have known these terms since grammar school. Not only has the computer age had a profound effect on communication, information access, and more recently, direct purchasing, it also has had a significant impact on our field of medicine. Complete textbooks of medicine, the Library of Congress, "virtual" libraries and medical websites are just a click away for physicians and patients. Instantaneous communication by e-mail is becoming the preferred mode of messaging, and discussion groups on any conceivable medical topic are available to anyone with Internet access.

This issue of *MASA Review* is devoted to topics concerning medicine on the Internet—finding medical sites for patients to use for reliable information, telemedicine, infomatics and regulation of information on the Internet. Currently, there is no quality control of information on websites and the reliability of data or opinions is determined only by the individual or institution that distributes it. This issue of *MASA Review* is designed to help you find information and avoid pitfalls as the versatility of cyberspace meets medicine.

The Internet is providing new opportunities and new challenges for physicians. At the AMA's Annual Session in June, the House of Delegates passed Resolution 832, Guidelines for Medical Practice through the Internet, which focused primarily on Internet prescribing. The resolution encouraged the Federation of State Medical Boards to develop model state legislation which would establish limitations on Internet prescribing and prevent illegal prescribing of medications without patient contact. Our Alabama State Board of Medical Examiners is currently addressing this issue and has already adopted regulations for telemedicine.

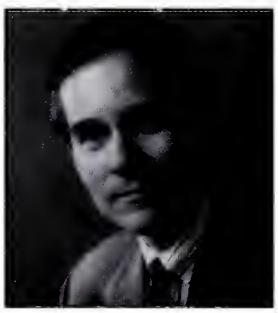
It is most appropriate that this issue, the last issue of *MASA Review* for this century, be devoted to the tools which will give us the greatest access to information and knowledge in the next millennium—the computer and the Internet.

— Pink Folmar, MD, President

A NOTE FROM THE EDITOR

Recently, patients have brought me some heavy reading:

- An armload of articles on Chronic Fatigue Syndrome
- Information on the use of human growth hormone for a variety of ailments
- Labels from health food stores
- Treatments, conventional and otherwise, for fibromyalgia
- Nutritional and herbal treatments for hypertension
- *The Black Death*, the story of the medieval bubonic plague



Except for the last item, all the others included a significant amount of information downloaded from somewhere on the Internet. All of us now have such experiences regularly. My impression is that since the use of the Internet became widespread, the frequency, complexity and volume of such patient requests involving information from all sources, not just the Internet, has increased dramatically.

Patients at times want me to evaluate what they bring, but just as often, it seems they bring it to further my education and to convince me to prescribe what is being advocated. Neither of these expectations is new for physicians or for *MASA Review*. In our Winter 1998 issue, we surveyed the challenges of alternative medicine, an area rife with unverified claims and a frequent source of patient/physician miscommunication.

And what about us? Medical students consistently bring material from Internet searches to answer questions from morning report or rounds. Practicing physicians more and more rely on "the net" as an essential addition to their reference shelf, sometimes even while they are seeing the patient. We need a way to manage both the volume and the quality of what we find in those searches.

That's hard enough, but there is something else that bothers me about the information from websites and other Internet sources. While it is true that some of it is just as unverified as some of the printed material on alternative medicine, there is also a different mindset at work here. It's

see Editor, page 19

EXECUTIVE DIRECTOR

The Trials and Tribulations of Technology

Can't live with it...can't live without it.

I'm not talking about relationships here, I'm talking about technology!

Medicine, of course, has been a leader in technological advances, but now we're talking about using advanced technology in everyday activities.

Here at the Medical Association of the State of Alabama, we've formed a Technology Committee within our staff to address the issues of applying technology in serving you, our members, as efficiently and effectively as possible.

This is how we're spending your dues dollars (besides becoming Y2K compliant!):

• **Database**—we've upgraded our database management system to capture more information so that we can use a single database to target our members by county, age, sex, specialty, zip code, legislative and congressional districts, MASA committees, offices held (county or state level), participation in MASA activities and more. With a more comprehensive database we'll be able to send you targeted communications and save money.

By the way, thanks to all 4,000 of you who returned the demographic update forms. You've been a great help in updating our current information.

• **Website**—*www.masalink.org* is our website address which is our Internet link to you. Staff has been working with Brad Frisbie, MD on the website. We appreciate how much time and expertise Dr. Frisbee has lent to MASA to get the site where it is today. Now, the Technology Committee is working to make it even more useful to the members. Already, there is quite a bit of information on the website, including legislative, legal, practice management, education, and MASA activities, as well as links to other websites of interest and relevance to physicians. This site will be updated continually and renewed as technology changes.

• **Managed Care Common Application**—MASA worked with the Alabama Association of Health Plans and the Medical Group Management Association to agree on a common application form for joining a managed care panel. The application is in electronic form and we are working on it being one which can be pre-populated with information from our database. Then, all a physician has to do is download it, fill in the information we don't have, save it and then send it as needed to a managed care organization which recognizes the form.

• ***Alabama MD***—Our Technology Committee is working to have the *Alabama MD*, your newsletter, sent to you via e-mail and available on the website, rather than in your regular mail (otherwise known as "snail mail"). Members would have the option to receive the newsletter electronically versus having the printed version mailed to them. Long-term, this could save thousands of dues dollars and increase our communications effectiveness.

• **Dues Payment**—You can buy a car on the Internet, why not pay your dues? This is a priority for the Technology Committee. We're working now on getting credit card safeguards in place and discussing how this can be accomplished. We may not have it for dues renewals this year, but it should be in place in the very near future. Again, there are thousands of dollars of savings potential here in printing and postage costs.

• **Apply for Membership**—Just as we hope to be able to allow dues payment via the website, we're trying to make it possible for non-members to join using that convenient avenue. This is also a priority.

These are just a few of the areas where we're trying to position MASA to take advantage of some of the technology available to us. As you can tell, a lot of stuff is under construction, but we're working hard to incorporate these changes. And, we will continue to enhance our technology and avenues of communication.

If you have any ideas as to anything else we should be working on from a technology standpoint, please contact me at cary@masalink.org (or you can use Ma Bell at 800/239-6272).★

— Cary Kuhlmann

The Millennium in Medicine

by Joel C. Pittard, MASA Immediate Past President

Advances in medicine during this millennium have had a profound effect on civilization, but until 1800 physicians had little influence on health. The major causes of death were infections--with regular epidemics of plague, flu, smallpox, cholera, yellow fever, syphilis, malaria and tuberculosis eradicating significant portions of the populace. Between 1347-1351, one particularly serious epidemic of plague, known as the "Black Death," killed 75 million people, over one third of the population of Europe. In the 17th century the average life span was 30 years with 20 percent infant mortality and 40 percent of children dying before they reached age 15.

Physicians in the Middle Ages, though treated with respect, had little to offer people other than the time honored therapy of their attendance and their attention. A more important factor for survival was sanitation of water supplies and sewage treatment as well as improved nutrition. Draconian quarantine measures had a small impact on some epidemics. The one significant advance against infectious disease was the beginning of eradication of smallpox. In 1717, the wife of a noble, Lady Mary Wortley Montagu suggested smallpox inoculation. Jenner later used cowpox (vaccinia) against smallpox, thus discovering our first vaccine.

There was little medical science prior to 1754, when James Lind of the Royal Navy conducted the first clinical trial, discovering that citrus prevented scurvy. Lind also made the famous statement which held true through the 19th century, "armies lost more men to sickness than to the sword." Diagnostic medicine prior to 1800 was largely a matter of history taking with minimal physical examination, touching of the patient, more or less forbidden due to social etiquette and sexual propriety, and to traditional diagnostic teaching. Surgery consisted of removing bullets and other missiles, amputations, bloodletting and draining abscesses. Hospitals were the spreaders of disease, places people went to die. On the political side, in 1509, physicians began a movement, which continues today, for licensing only qualified doctors.

With the Industrial Revolution, significant medical advances began. Bichat advanced our understanding of disease with clinical pathological correlation through autopsies. Laennec invented the stethoscope improving our diagnostic skills. In 1803, Percival wrote a treatise on medical ethics which is the backbone of our medical ethics today. Claude Bernard advanced our knowledge of physiology. Semmelweiss discovered that physician hand washing decreased the rate of childbed fever, which had a huge mortality rate at the time. Pasteur discovered that heating wine to a certain temperature prevented its souring, and applied this technique of pasteurization to milk and beer, leading to the sanitation and preservation of foods.

Two discoveries revolutionized surgery: ether anesthesia by Long and Morton and principles of antisepsis by Lister. The poor had a markedly shorter life span compared to the affluent, primarily due to overcrowding and wretched living conditions. This led to public health Laws. The discovery by John Snow that cholera was water borne led to water purification in municipalities. With the founding of the AMA and MASA in the mid-19th century the impetus was to form health boards for the licensing of physicians and removing the unqualified from practice.

By 1900, measures of improved health were evident as civilization was losing its population check: infectious disease.

Discoveries in the 20th century are too numerous to list: Roentgen's discovery of X-ray, the use of sulfonamides in the 1930s, penicillin in the 1940s; advances in equipment due to the improvement in basic materials, steel and other metal alloys, latex and plastics; then

see Millennium, page 15

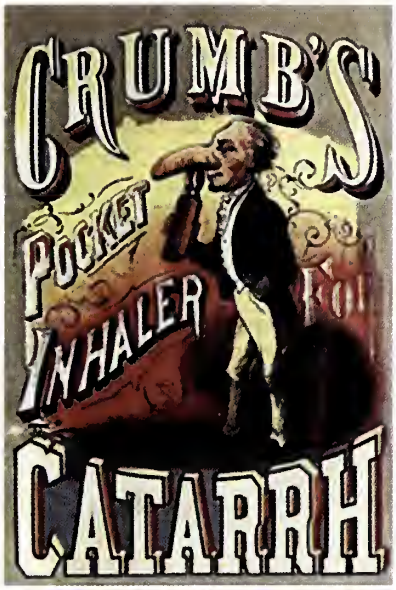
Fraudulent health claims: Don't be fooled

Special to MASA Review
by Federal Trade Commission staff

Consumers waste billions of dollars on unproven, fraudulently marketed and sometimes useless healthcare products and treatments. In addition, those with serious medical problems may be wasting valuable time before seeking proper treatment. Worse yet, some of the products they're buying may cause serious harm.

Consumers may think that just because a plant or herb is "natural" or unprocessed, it's safe. That's not true. Unlike prescription or over-the-counter medicines, herbs and other food supplements do not have to undergo review for safety or effectiveness before they are marketed. Some "natural" products, like herbs, may have powerful pharmacological effects that could present risks for people who take other medications or who have specific medical conditions.

Consumers may get taken in by promoters' promises, especially when successful treatments have been elusive. But the fact is that when it comes to claims for health-related products, a healthy dose of skepticism may turn out to be the consumers most promising prescription.



How to spot false claims

Consumers should remember the first rule of thumb for evaluating any health claim: If it sounds too good to be true, it probably is. They also should be on the lookout for the phrases and marketing techniques fraudulent promoters typically use to deceive consumers.

• The product is advertised as a quick and effective cure-all for a wide range of ailments.

•The promoters use words like "scientific breakthrough," "miraculous cure," "exclusive product," "secret ingredient" or "ancient remedy."

• The text is written in "medicalese"– impressive-sounding terminology to disguise a lack of good science.

• The promoter claims the government, the medical profession or research scientists have conspired to suppress the product.

• The advertisement includes undocumented case histories claiming amazing results.

• The product is advertised as available from only one source, and payment is required in advance.

• The promoter promises a no-risk "moneyback guarantee." Consumers should be aware that many fly-by-night operators are not around to respond to a request for a refund.

Why health fraud schemes work

Health fraud is a business that sells false hope. It preys on people who are victims of diseases that have no medical cures, such as HIV/AIDS, Alzheimer's, arthritis, multiple sclerosis, diabetes and certain forms of cancer. It also thrives on the wishful thinking of those who want short-cuts to weight loss or improvements to personal appearance. It makes enormous profits beeause it promises quick cures and easy solutions to better health or personal attractiveness.

Cancer

A diagnosis of eancer can bring feelings of fear and hopelessness. Many people may be tempted to turn to unproven remedies or clinics that promise a cure. Although some cancer patients have been helped by participating in legitimate clinical trials of experimental therapies, many others have wasted time and money on

see Claims, page 6

Claims, con't from page 5

fraudulently marketed, ineffective and even dangerous treatments.

When consumers evaluate cancer cure claims, they should keep in mind that no single device, remedy or treatment is capable of treating all types of cancer. Cancer is a name given to a wide range of diseases that require different forms of treatment best determined by a physician.

Resources: The American Cancer Society (check your local yellow pages). To order free publications on cancer research and treatment, consumers can call the National Cancer Institute's Cancer Information Service at 1-800-422-6237.

HIV and AIDS

People diagnosed with HIV, the virus that causes AIDS, also may feel pressured to try untested "experimental" drugs or treatments. Although there are legitimate treatments that can extend life and improve the quality of life for AIDS patients, there is, so far, no cure for AIDS. Trying unproven products or treatments can be dangerous, and may delay proper medical care. It also can be expensive and usually is not covered by insurance.

Consumers should avoid being pressured into making an immediate decision about trying an untested product or treatment. They should ask for time to get more information from a knowledgeable physician or healthcare professional. Legitimate healthcare providers will not object to providing additional information.

Resource: The federal HIV/AIDS Treatment Information Service, 1-800-HIV-0440.

Arthritis

Consumers who suffer from one of the many forms of arthritis should be aware that this disease invites a flood of fraudulent products and services. This is because medical science has not yet found a cure for arthritis. The Arthritis Foundation advises that symptoms should be monitored by a physician because the condition can worsen if not treated properly.

Consumers spend an estimated $2 billion a year on unproven arthritis remedies. Thousands of dietary and natural "cures" are sold for arthritis — mussel extract, vitamin pills, desiccated liver pills, shark cartilage, and honey and vinegar mixtures. Many supplements marketed as arthritis remedies are not backed by adequate science to determine whether they offer any relief.

Resource: The Arthritis Foundation, 1-800-283-7800 (9 a.m.-7 p.m., eastern time, Monday-Friday). Arthritis Foundation, P.O. Box 19000, Atlanta, Ga., 30326.

Precautions for taking dietary supplements

Thousands of dietary supplements are on the market. Many contain vitamins and minerals to supplement the amounts of these nutrients that people get from the food they eat. There also are many products on the market that contain other substances like high-potency free amino acids, botanicals, enzymes, herbs, animal extracts and bioflavanoids.

The Food and Drug Administration's (FDA) review of the safety and efficacy of these products is significantly less than for drugs and other products it regulates. Consumers should be cautious about using any supplement that claims to treat, prevent or cure a serious disease. The FDA has approved only a few claims for labeling, based on a review of the scientific evidence (for example, claims about folic acid and a decreased risk of neural tube defect-affected pregnancies). The FDA allows other disease claims on supplement labels only if they are based on authoritative statements from scientific organizations like the National Academy of Sciences.

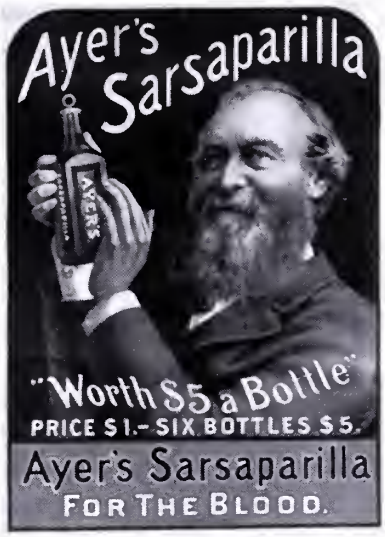
Some dietary supplements have documented benefits; the advantages of others are unproven and claims about those products may be false or misleading. Questionable claims may involve products or treatments advertised as effective in shrinking tumors, curing insomnia, reversing hair loss, relieving stress, curing impotency, preventing memory loss, improving eyesight and slowing the aging process.

In addition to lacking documented effectiveness, some dietary supplements may be harmful under some conditions. For example, many herbal products and other "natural" supplements have real and powerful pharmacological effects that could cause adverse reactions in some consumers, or cause dangerous interactions with other medicines. It doesn't necessarily follow that supplements marketed as "natural" are safe and without side effects. The FDA monitors reports of adverse reactions to

Claims, con't

dietary supplements to identify emerging safety issues.

According to the FDA, the following substances in dietary supplements are among those that can raise serious safety issues: chaparral, comfrey, lobelia, germander, willow bark, ephedra (ma huang), Ltryptophan, germanium, magnolia-stephania preparations and dieter's teas. In addition, some vitamins and minerals can cause problems for some people when taken in excessive doses. Finally, a label of "natural" is no guarantee of a product's safety or effectiveness.



Consumers who use dietary supplements should always read product labels to determine the percentage daily value for various nutrients in the product. Also, it's a good idea for consumers to seek advice from a health professional before taking dietary supplements.

To report a problem

To report a company that may be making false advertising claims, consumers should contact:

The Federal Trade Commission by phone, toll-free, at 1-877-FTC-HELP (3824357); TDD: 202-326-2502; by mail to Consumer Response Center, Federal Trade Commission, Washington, DC 20580; or online at www.ftc.gov — click on Complaint Form.

Consumers may also contact their state Attorney General's office, state department of health, or local consumer protection agency.

To report a company for falsely labeling its products, consumers should call their local FDA office.★

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For information and Y2K resources, call 1-800-958-4232 or visit www.hcfa.gov/y2k

Medicare is Y2K ready. Are you?

Medicine meets Cyberspace:

The Internet has transformed the marketplace and the global economy.

A rural physician can have immediate access to specialists located hundreds of miles away for consultation. Examinations can be performed without the doctor being physically in the room with the patient. Medical information can be digitized and transmitted within milliseconds.

Digital technology is becoming a reality. But can medicine adapt?

Computers and Information Technology—an answer looking for a problem?

"More often than not, physicians have been presented "an answer," whether it be computer programs or other technology, by experts, sales people, or vendors who don't have a clue about what our problems are," said H.C. "Moon" Mullins, one of the state's leading experts on digital and information technology in medicine. "Managing the voluminous paperwork; transmitting clinical information to others such as insurance, consultants, hospitals or laboratories; providing clinical information to the physician at the time and place of care—many of these problems can be addressed through the use of information technology (such as computers) and telecommunications."

Providing clinical information at the point and time of care.

How much clinical information is needed at the time of care in the ambulatory setting? Is that need being met?

In a study of 49 physicians (Covell) researchers examined how frequently medical information was needed and accessed. In a questionnaire, physicians said they only needed to seek information not already in their head once a week, Dr. Mullins said. "The reality is that they needed to have additional clinical information in more than 66 percent of the patients they examined. And of that needed 66 percent, useful information was sought and found only five percent of the time," he added.

Until now, the development and use of computers and information technology in health care has been in the in-patient setting, usually referred to as "Hospital Information Systems." These systems have not been helpful to physicians or to the patients who get a great majority (90 percent) of their care in the ambulatory setting, Dr. Mullins said. The greatest need

now, is to use available technology to provide the needed clinical information to the provider in the ambulatory setting, in the examining room while the patient is being cared for. That is, at the time and place of care. "We have to shift the focus on information management from financial to clinical, and from hospital to ambulatory," he said.

In a discussion about clinical information, it is helpful to understand the fundamental differences in the words "knowledge" and "information." Knowledge is the organized body of facts we acquire through reading, study or practical experience that is contained in our head, our brain. Information, however, is an idea or fact that is not contained in our head. That lies somewhere outside our head. That's where the computer can play a role, Dr. Mullins said, providing information (lying elsewhere) to us to be used while seeing patients.

"The whole movement to evidence-based medicine revolves around the conscientious, explicit and judicious use of current best evidence from clinical care research in the management of individual patients. You select a specific clinical question from the patient's problem, search for relevant clinical information, appraise your findings and then implement them. How current is your information? What did you base that decision on? If you look at printed publications, they are frequently out of date. If you rely on colleagues, you should ask for the authority or source of the information or opinions offered. If you go to Medline, Grateful Med, Ovid, or the web and do a quick search, you may get thousands of articles returned. How do you cull through all that information quickly?" he said. "With the volume of medical information out there—over a thousand new referred medical journal articles a day—it is impossible to keep up with it all and remember it."

A physician needs "just in time" information at the point of care, Dr. Mullins said. "The computer can be used to handle the analytic, mindless tasks that we do so poorly--such as patient recall, allergic reactions, drug lists, drug interactions and prescription writing--leaving us more time to do what we do best, caring for patients. The whole purpose should be to empower the individual—to move decision making from a hierarchy to the person at the point of care," he said. "The technology available today is nothing new—electronic medical records and electronic clinical information systems were developed as early as the 1970s."

"Perhaps the greatest value of computers in medicine will be to do those rote, repetitive, logical left brain tasks that we do so poorly and relieve our right brain to do those things that we do so well - caring for patients."
Professor Francoise Gremy

Climbing the mountain of information

One of the major challenges, however, is breaking down the "capture of individual practices and providers" that many large healthcare systems are tending to do.

"At the time health care was organized into vertical systems, much of the world had begun deconstructing such systems," Dr. Mullins said. "The USSR, for example, divided into Republics. IBM and ITT divided into units. Decentralization and horizontal networks were the trends—except in the healthcare industry."

The United States healthcare system has undergone several stages of evolution, Dr. Mullins added. From unstructured independent practices and loosely framed HMOs, the movement has been one of consolidation and a vertical enterprise—business is managed from the top down.

"The technology available today will change that system, flatten the hierarchy. We are fundamentally changing how we learn, how we practice, how we research and how we work. Technology requires whole new ways of doing things. Even now, CNN, the *Wall Street Journal* and *New York Times* are on the web providing more information to the public than they do in their broadcasts or printed publications. Multimedia is playing a larger role in every aspect of our lives. If you want to know more about a story you see on television, you visit the website," he added.

The control of information is moving from the source to the user. Traditionally, information has been "pushed" from a hierarchy above to the user. Now, the trend is for the user to "pull" the information he or she needs from the source. Information is controlled by the person seeking it rather than from above.

"You have control over the information you receive via the web. The user can subscribe to all information and then decide what he wants to review," he said.

You Ain't Seen Nothing Yet!

"When Admiral Dewey sailed into Manila Bay in the 1890s, the natives only saw fish and birds. They were unable to see ships because they had no experience with such things, and no concept of them. The situation is similar today—many people are unable to conceptualize the future impact of the digital world because

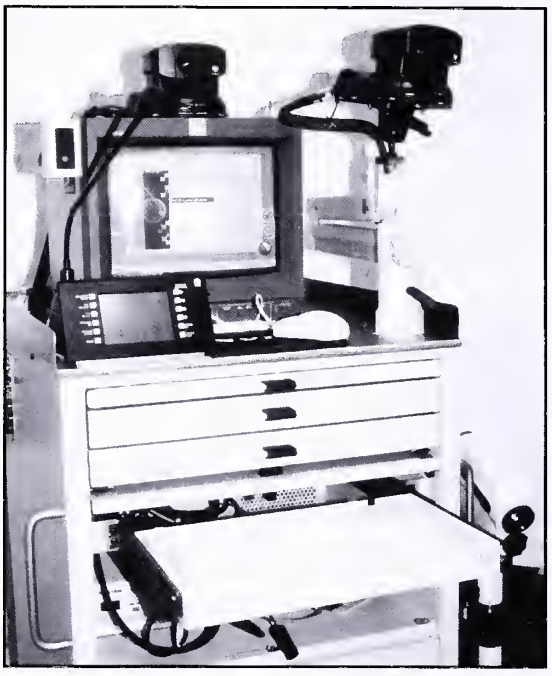
see Information, page 11

Telemedicine to change face of patient care

Imagine a cardiologist listening to your heartbeat from 200 miles away as he evaluates what information your regular doctor has electronically transmitted to him on your case. Sound unrealistic? Guess again.

Telemedicine is a burgeoning field which has enabled many rural physicians an opportunity to have their patients see a specialist without ever having to leave town.

"The telemedicine system provides interactive full-motion capability so there's no delayed time or stop-action to disrupt the patient's visit with the specialist," said J. Raymond Fletcher, MD, Ph.D., medical director for the University of South Alabama (USA) Telemedicine Services. "The physieian sees patients the same way—specialized medical equipment enables the physician to monitor the patient's heart rate, temperature or blood pressure. The cameras and sound quality are very clear—so much so that it does seem like the physician is in the room with the patient."



The Doctor will see you now: This telemedicine unit enables the physician located in another city to speak directly with the patient and, with assistance, use cameras to examine the patient and monitor vital signs.
Photo courtesy of USA Telemedicine Department

An examination in action. Via cameras, the physican located in another area of the state can examine the patient. Computers keep the action in real time without jerks and delays, so the patient and the physician can have a live conversation.
Photo courtesy of USA Telemedicine Department

Appointments are set up for the patient like he or she is going to the specialist's office, however, when the appointment day comes, the physician and the patient are miles apart. A television screen is placed in the physician's office and another is set in the examining room. A nurse or nurse practitioner presents the patient, using equipment and moving the cameras as necessary to enable the physician to examine the patient.

"The patient doesn't have to travel. Transportation is often difficult for rural families," Dr. Fletcher said. "Telemedicine is ideal for high-risk OB situations. The specialist can do real-time ultrasounds and the family doesn't have to travel to Mobile or Birmingham. Additionally, if there is a high-risk infant in the neonatal intensive care unit, the local physician can consult with a specialist to determine if the child needs to be transported to another facility or if the infant's needs can be taken care of on-site. Post-surgery follow-up is also available. If a patient has had surgery, for example, he can be seen and followed by the specialist via a teleconnection rather than another long trip to the hospital--wherever it may be."

Telemedicine has been touted as the wave of the future in terms of healthcare delivery. X-rays and other tests can be digitized and electronically transferred between physicians. Grand rounds via teleconferencing can provide rural physicians with new techniques and educational opportunities without having to leave their offices or their patients.

"The possibilities are endless," Dr. Fletcher said. "Homes could have a direct communication link to their physician's offices. The future is bringing health care directly to the patient and getting out of the hospital setting. Health education and preventive medicine is the trend. Physicians will have virtual offices, not real offices."

Because of the tremendous start-up costs, universities are getting involved in telemedicine projects. USA, for example, is in the second phase of a federal grant from the Office for the Advancement of Telehealth which is part of the Office of Rural Health Policy in the Department of Health and Human Services. The program,

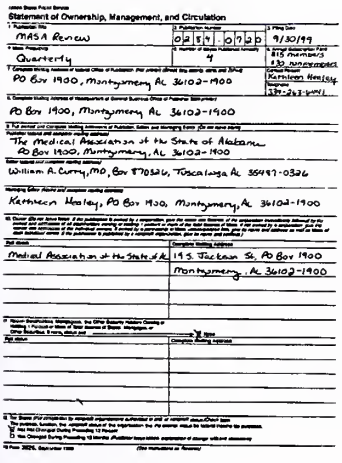
see Telemedicine, page 11

Telemedicine, con't

which has several facets, has focused on creating communication links among all university hospitals, ambulatory care clinics, and rural hospitals and clinics.

"The success of technology and incorporating it into the medical field is to make it as easy as possible for the physieian and the patient to participate," Dr. Fletcher said. "In order to make it seamless, a great deal of education must be done on everyone's part. There's no question that this is where the future is—it's just a question of time."

Editor's note: Alabama has a licensing law which defines and regulates the practice of medicine across state lines (telemedicine). Under the law, a special purpose license or a regular license must be obtained to practice medicine or osteopathy across state lines in Alabama. The special purpose license is secured by obtaining a certificate of qualification from the Board of Medieal Examiners and a special purpose license from the Medical Licensure Commission. The holder of a special purpose license, which is valid for three years, is required to comply with all laws, rules and regulations governing maintenance of patient medical records, including patient confidentiality requirements regardless of the state where the medical records of any patient living in this state are maintained. There are two exceptions to the requirement to obtain a special purpose license to practice medicine across state lines: a physician who engages in the practice of medicine in a medical emergency or a physician who engages in the practice of medicine across state lines on an infrequent basis (less than 10 times per calendar year or involves fewer than 10 patients in a calendar year or comprises less than one percent of the physician's diagnostic or therapeutic practice). Under a reciprocity provision in the law, a special purpose license may only be issued to a physieian who practices in a state or territory whose laws permit or allow for the issuance of a similar license to a physician practicing in Alabama.★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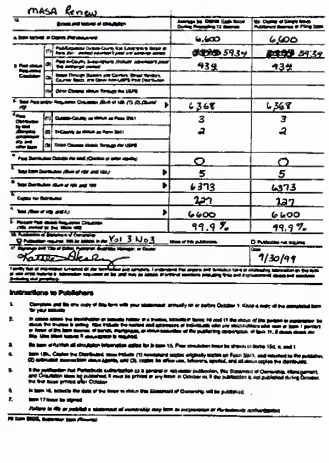
The Medical Association of the State of Alabama
PO Box 1900, Montgomery, AL 36102-1900

William A. Curry, MD, Box 870326, Tuscaloosa AL 35487-0326

Kathleen Healey, PO Box 1900, Montgomery, AL 36102-1900

Medical Association of the State of AL 19 S. Jackson St. PO Box 1900
Montgomery, AL 36102-1900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Instructions to Publishers

Information, con't

we have not yet explored and experienced it. It will require totally new ways of thinking and doing things that we can not yet imagine."

The move will be toward horizontal networks and away from the vertical structure the healthcare industry is in now, he said. "Self-contained, self-managed practices will be supported in real time by expert biomedical, informational and management resources. This information will fully empower the physician to do whatever it takes to serve patients at the same time providing assessment and accountability," he added. "Individual practices will be linked together with pockets of expertise—both clinical and informational—to aid the physician at the point of care. That is where our future lies."

Suggested reading:

Global Paradox by John Naisbitt
Liberation Management by Tom Peters
Being Digital by Nicholas Negroponte
Turtles, Termites and Traffic Jams by Mitchel Resnick
Textbook of Wisdom by Edwar DeBono
"Information Needs in Office Practice: Are They Being Met?" Covell. Ann Intern Med, 1985
"The Quality of Care and the Non-Perfectibility of Man" McDonald. NEJM, 1976★

Prescribing medications via the Internet

The use of the Internet for obtaining prescription drugs, while legal, is open to questionable practices. There is particular concern where there is no proper patient-physician relationship and no proper pharmacy intermediary. Missing these critical elements bypasses usual safeguards to ensure that the patient's needs are being met.

How to handle this growing field is a concern involving not only the Medical Association of the State of Alabama but such national organizations as the American Medieal Assoeiation, the Food and Drug Administration and the Federation of State Medical Boards. These agencies are working in partnership to set guidelines to ensure the safety of the patient and professional conduct of the physician.

The Alabama Board of Medical Examiners has not adopted a formal policy position on this issue, but is currently investigating the possible involvement of Alabama licensed physicians in Internet prescribing without a valid physician-patient relationship.★

in actual clinical practice: problems and prospects

by Steven MacCall, Ph.D.

Awareness and use of the World Wide Web (WWW) by clinicians has exploded at a pace faster than any other type of information technology. Yet problems remain for its full integration into the daily decision making routine of all members of the clinical care team. Health sciences libraries as well as digital libraries are attempting to address some of these challenges.

Problems preventing routine use of the web in the clinical environment

The problem of quality control for web-based clinical information resources is a key concern for clinicians and patients alike. Recent articles in the news media have pointed out that using the web to find health and medical information is fraught with peril. Headlines such as "Point-and-Click Medicine: A Hazard to Your Health" and "Of Fact, Fiction and Medical Web Sites" underscore the general position of the press toward the quality of health information on the web. The central problem with the web is that it is not inherently a quality controlled environment. Any person having an account with an Internet service provider is able to publish information to the web, including legitimate and illegitimate sources of medical and health information.

This is not a new problem for the medical community. Evaluating sources of information has always been a key part of the process of decision making in the clinic. For example, pharmaceutical representatives often provide important and recent information on new drug indications; however, the clinician must note the source of that information. This does not mean that the pharmaceutical representative should not be used as an information source. Rather, it is an example that points out that good information can be obtained from just about any source, just so long as the source of the information is known and thus the source, itself, can be evaluated for its veracity and point of view [1].

The medical community has responded to the problem of quality control on the web. For example, recent formal studies analyzing the quality of web site information can be found in the Journal of the American Medical Association and BMJ [2]. However, much more needs to be done to make the web a reliable source of information for clinical decision making.

A second problem preventing widespread use of the web in clinical environments concerns its efficiency in providing consistent and reliable access to specific information resources. There is much research on the general information needs of clinicians. It is known that many clinicians rely on their personal libraries and on colleagues for asking questions about clinical cases [3]. While these two approaches for obtaining information are very helpful and can lead to successful patient care outcomes, there can be some significant problems with their use over time. For example, unless reference books in one's personal library are kept up to date with the latest editions, then the clinician may be relying on old information that does not reflect the current standard of care. In addition, unless colleagues are also keeping themselves well read, clinicians may also be relying on their knowledge, which itself may not reflect the current standard of care.

The primary reason that clinicians rely on personal libraries and colleagues for information concerning patient care decisions is due to convenience and ease of use factors that play a critical role in the efficient retrieval of information during real time patient care. However, a computer that is

Web, con't

connected to the Internet can create a formidable barrier to timely information retrieval. Like many in society, clinicians may not feel comfortable with using computers or may have had bad experiences with past use. Unless this problem is directly addressed with better computer interfaces and with appropriate levels of training and computer support, the web may not even have a chance to penetrate into the majority of clinics and be used by clinicians to the extent that personal libraries and colleagues are for information lookup.

The web, itself, can contribute to the inefficiency problem if clinicians rely solely on a class of information retrieval tools commonly referred to as "search engines." Advertisements for these tools beckon all comers with the lure of simple keyword searching and promise the delivery of relevant information. However, the result of search engine searches is often thousands, if not tens of thousands, of documents. Though some of these documents may be of high quality and may be highly relevant to a specific clinical case, they are often mixed with poor quality and irrelevant documents that prevent the efficient retrieval of the best information. The overuse and misuse of search engines to retrieve clinical information is a major barrier to efficient use of the web.

Response to WWW quality and efficiency problems by health sciences libraries and digital libraries research

Health sciences libraries have responded to the problem of web quality control by extending their professional practices to the digital resources of all types. For health information professionals, the web is simply another tool to be adopted in their mission to meet the information needs of various constituencies of their parent institutions regardless of location. Two current examples in Alabama are the "Links to the World" page [4] on the University of Alabama-Birmingham Lister Hill Library of the Health Sciences web site and the "Medical Subjects" page [5] of the University of South Alabama Biomedical Library web

see Web, page 16

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Conversations with a Southern Gardener
by Ed and Peggy Givhan
The Beech Hill Corporation:
Safford, Alabama, 1999
282 pages

Ed and Peggy Givhan, Montgomery internist and judge respectively, have just completed the publication of their delightful gardening book designed specifically for those who live in Alabama, particularly the Montgomery area. They write from the point of view of their local experience, but they have also traveled widely and viewed many gardens. The forward proclaims that "this book tells you what to grow, when to plant it, and how to grow it." He argues that "gardening is arguably the favorite hobby of the South (even ahead of football!)" Well, I don't know about that! The style is "colloquial and conversational" according to Dr. Givhan, a statement with which I would agree. It is easily read cover to cover or by using it as a reference guide to look up various aspects of gardening. The book is complete in that it gives the gardener a task to perform year round. It creates a warm and friendly aura of good times with peaceful repose, planning and executing your garden. Each step is meticulously planned. Gardening is presented as being as simple or complex as you wish or have time or space for. Reading this book enhanced my green thumb. In fact, I ordered several seed catalogues immediately.

This is Dr. Givhan's third book on gardening, which he has authored or co-authored, the first being published in 1980, *Flowers for a South Alabama Garden.* Copies are available at your local book store, including the Capitol Book and News in Montgomery.

❖ ❖ ❖ ❖

Consilience
The Unity of Knowledge
by Edward O. Wilson
New York: Alfred A. Knopf, 1998
298 pages

Consilience is a scholarly treatise by Professor Wilson. It attempts to distill and consolidate knowledge. He grew up in Alabama with an interest in "ants, frogs, and snakes, as a wonderful way to stay outdoors." Dr. Wilson received his bachelor's and master's degrees in biology from the University of Alabama. He subsequently earned a Ph.D., became a Harvard professor, and is currently Pelligrino University Research Professor and Honorary Curator in Entomology of the Museum of Comparative Zoology at Harvard University. A Pulitzer Prize winner, Wilson is one of the world's greatest authorities on ants. His is a preeminent voice in the current debate on evolutionary sociobiology, a hotly debated topic of scientific and public debate.

His book ambitiously reviews the general state of scientific understanding framed in an historical framework. His explanation of The Enlightenment is marvelous. His historical background is eloquent. Science is described as "a combination of mental operations that has become increasingly the habit of educated peoples, a culture of illuminations hit upon by a fortunate turn of history that yielded the most effective way of learning about the real world ever conceived." Science has allowed us to escape "confinement and prodigiously extended its grasp of physical reality." Dr. Wilson strives to incorporate the mind, genes, human nature, social sciences, the arts, and ethics and religion, each with a separate chapter, into the whole of human understanding. He concludes that "ethics is everything" and further reasons that consilience ought not to "imprison creativity." He clearly opposes a scientific cult of narcissism.

This book will stimulate both physicians and the general reader. It is controversial, as is his style. Read this book, learn, be stimulated, and be proud of our fellow Alabamian.

❖ ❖ ❖ ❖

Rx For the Soul
by David B. Wilhelm, MD
Thomas Nelson Publishers:
Nashville, 1997
ISBN 0-7852-7245-3
213 pages

David Wilhelm, MD is a Birmingham physician who has written a book comprised of a series of anecdotes of his adventures involving

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advanced imaging techniques, lasers, and fiberoptics; new and improved vaccines, surgical techniques and marked advances in drug therapy.

As society became healthier, our focus has changed from treatment to prevention. Chronic disease states have replaced infections. We now deal with dysfunctions hardly acknowledged in earlier times--arthritis, ulcers, back pain, strokes, depression and the assorted maladies of living longer.

Now, with the rapid expansion of the Internet, we face another dilemma. On the one hand, it gives us dramatically improved access to useful medical information. On the other, there's unscientific, invalid and downright dangerous information.

Now, with the rapid expansion of the Internet, we face another dilemma. On the one hand, it gives us dramatically improved access to useful medical information. On the other, there are an estimated 15,000 websites covering some aspect of medicine, and over 15 million people currently using these sites. Many of these sites are commercial, providing unscientific, invalid and downright dangerous information. Now unscrupulous practitioners are using this medium to prescribe to patients they have never met. To date there has been no effective regulation of these practices. We can look for even more traffic and, as yet undefined, problems to surface.

Roy Porter sums it up this way, "...medicine's finest hour is the dawn of its dilemmas. ...Today, with mission accomplished, its triumphs are dissolving in disorientation. Yet as those expectations become unlimited, they are unfulfillable: medicine will have to redefine its limits even as it extends its capacities."

How can we address the Internet, managed care and telemedicine while still maintaining our relevance as a profession? As individuals, we all know our roles...advocate for our patients, follow the rules of medical ethics, keep up to date with advances in our fields, use evidence-based treatment regimens, and never put our own interests ahead of those of our patients. We also have a duty to the profession, to report unethical practices, to decry unnecessary or unsubstantiated procedures and treatments, to promote the public health, and to be active in organizations such as MASA, AMA, and our specialty societies, which can help us define and achieve our goals.

We must stay strong as a profession lest others (mid level practitioners, pharmacists, health insurers, alternative practitioners, Internet content providers, government, and the medical industrial complex) move in to fill the void. Individual physician-patient relationships involving trust and a strong medical association are the best assurances for the continued good health of our patients, and, thus, our relevance as a profession.★

Editor's note: The preceding article was excerpts from Dr. Pittard's speech at the 1999 MASA Annual Session.

BOOK REVIEWS

the spiritual aspects of his medical practice. He tells his "story" and the stories of those he encounters in his medical practice through anecdotal vignettes. Expressing the hope that the reader will gain from his book the inspiration "to search for a greater knowledge of God," he forcefully expresses his own religious faith. That faith appears to be interwoven into each aspect of his life including his medical practice. His stories suggest that he spends significant amounts of time with his patients and seeks to comprehend their deepest emotions.

He appears to have experienced a wonderful life with much good fortune and minimum of adversity, which he wishes to share with others. He expresses appreciation for his good fortune. He is devoted to his wife and children. He describes his father as a "source of strength and encouragement, not only to my family, but also to countless others." His spiritual maturity makes him empathetic to the pain of other people. He prays for a young patient that "he could someday shed the scars of a painful childhood, that he could learn of love the way it was meant to be, that he could someday have a caring family with loving parents." He expresses appreciation for his good share of talents and opportunities from life's store of vagaries and humility in his own limitations. It is a nice book. More physicians need to tell their stories.★

Reviewed by David W. Hodo, MD
Book Editor

Web, con't

site. In both cases, these libraries provide and maintain access to a select list of quality WWW-based clinical information resources that have been evaluated by their professional staff.

In addition to finding long term solutions to the web quality control problem, there is currently digital libraries research taking place to address the issue of efficiency concerning web use within the constraints of everyday clinical practice. The University of Alabama School of Library and Information Studies, in partnership with the University of North Texas School of Library and Information Sciences, is conducting a research, teaching and service effort called the Clinical Digital Libraries Project (CDLP). The CDLP works with health sciences libraries to develop and test a model for providing large scale professional digital library services to clinical environments. Building on existing projects at health sciences libraries that are stressing quality control, the CDLP is tackling the problem of delivering these resources in a timely manner. The large-scale nature of the project results from an attempt to create a complete clinical reference digital library, including links to subscribed clinical resources (such as Harrison's Online, MD Consult and Stat-Ref) and quality free web-based clinical resources (such as the Merck Manual). In addition to clinical resources, there are links to patient and family information resources, preventive medicine and public health resources, electronic journals, and professional society and association web sites.

Currently the CDLP is being evaluated in clinical environments in fifteen states and three foreign countries in addition to various sites around the state of Alabama. Information about the CDLP is available at http://www.slis.ua.edu/cdlp/.

How to think about the web in the context of clinical use

The WWW is too important of a potential clinical resource to ignore. But how should clinicians think about the web given the concerns discussed above? One approach is not to consider the web, itself, as the source of information for clinical decision making. Rather, a clinician should view the web as a mechanism for retrieving sources of information.When viewed this way, all retrieved web-based resources come within a context, i.e., from a specific source rather than simply "from the web." The value of this approach is two-fold. First, when thinking this way, the clinician is encouraged to attempt to identify the author or the publishing entity. This is a critical first step toward judging the quality of web-based information resources.

More important, the second value of this approach is that it encourages the clinieian to seek web-based information resources that already have solid reputations for quality in the pre-web world. For example, the 17th Edition of the Merek Manual (1999) is freely and fully available from the Merck web site. Therefore, when seeking information from the online edition of the Merck Manual, the clinician can implicitly trust the retrieved information because of the longstanding reputation of the Merck Manual. As a variant on this approach, a clinician could use the web to seek information resourees for organizations that have a pre-web reputation. For example, many medical societies and associations have migrated their clinical guidelines and patient information brochures to the web.

In both cases, the seeking of existing resources such as the Merck Manual or the seeking of trusted resources from professional society or association web sites, the clinician is using the web as a means to retrieve documents

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Web, con't

with known quality, rather than considering the web, itself, as the source of information and thus being subjected to the whims of web search engines.

Despite the rhetoric of the popular press concerning the dangers of web use for medical information, there is significant progress being made to control the situation so that the web can reach its true potential for making a difference in the lives of the busy clinician. Health information professionals are hard at work extending their practices to the web environment. In addition, clinicians in Alabama, the Southeast and across the country are beginning to benefit from digital libraries research that is responding directly to problems confronting the use of the web in clinical environments. After these problems are fully addressed, the prospects for the world wide web are practically limitless.★

NOTES

1) Ziegler MG, Lew P, Singer BC. (1995). *The accuracy of drug information from pharmaceutical sales representatives*. JAMA;273:1296-8.

2) Jadad, AR, Gagliardi, A (1998). *Rating health information on the Internet: navigating to knowledge or to Babel?* JAMA, 279:611-614 and Eysenbach G, Diepgen TL. (1998). *Towards quality management of medical information on the internet: evaluation, labelling, and filtering of information.* BMJ 317:1496-1500. For a bibliography concerning quality issues on the WWW, go to http://www.bama.ua.edu/~smaccall/qualitybib.html.

3) Thompsom, M.L. (1997). *Characteristics of information resources preferred by primary care physicians.* Bulletin of the Medical Library Association 85:187-92

4) Available at http://www.uab.edu/lister/mevlink.htm.

5) Available at: http://southmed.usouthal.edu/library/www/index.html.

About the author:
Steven MacCall is assistant professor for the School of Library and Information Studies at the University of Alabama.

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Telemedicine: new approach, new liability

Every day seems to bring a new application of telemedicine. As pioneering physicians increasingly use telemedicine for a live interaction with a patient, consultation with medical colleagues or the ability to share and manipulate information, liability increases as well.

The chief concern of medical legal experts involves traditional concerns such as eonfidentiality, informed consent for evaluation and the formation of a physician/patient relationship. The technology involved just places these concerns against a new backdrop.

What should you do if you're involved in telemedicine, or considering venturing into that arena? Risk management experts suggest the following precautions and actions to help reduce your liability risks.

✓ Be educated on the technology used and the actions you are taking to share information.

1. Know the minimum specifications required for the use of the technology.
2. Employ and maintain the highest confidentiality controls possible.

✓ Be sure the use of telemedicine is appropriate.

If a patient is involved, he/she should know any options and/or limitations of using telemedicine.

✓ When contacting other physieians, know the physician's background and his/her preferred treatment.

1. All involved parties should comply with a basic documentation method to ensure proper recording is implemented from every individual.
2. Ensure compatibility with each physician.

✓ You should inform your insurance provider of your telemedicine actions and the scope of your involvement.

✓ If your telemedicine actions are not clear or do not provide enough information for proper recommendation or treatment, you should see the patient personally or suggest a follow-up consultation.

✓ You should be sure there is an accepted level of expectations and responsibilities from all involved parties before beginning any telemedicine acts.

Contractual issues should be reviewed and clarified-including those with other providers, vendors and equipment manufacturers.

✓ All involved systems should be archived.

1. A system should be maintained for performing and retaining backups of the used systems.
2. All office staff should be aware of their responsibilities.

✓ Attempts should be made to personalize every telemedicine encounter.

✓ Everything should be documented. Notes should be made or reeorded concerning equipment used and resolution.

By taking these precautions, you will not only practice using the latest technology, but also maintain security from emerging malpractice claims.

Physicians insured by Medical Assurance, MASA's endorsed professional liability carrier, may contact the company's Risk Resource Center for answers to liability questions and/or risk management by calling (800)282-6242 or via email at rmhelp@maih.com.

Medical Assurance Renamed

Mutual Assurance, MASA's endorsed medical liability carrier, has officially changed its name to Medical Assurance!

"We are establishing Medical Assurance as the brand name that represents financial strength, innovative underwriting and first-rate service in the field of health care professional liability and related coverages," said Medical Assurance Chairman and President A. Derrill Crowe, MD. "With this change, all of our insurance subsidiaries will be associated with a name that complements our singular focus on delivering the highest quality eoverage at competitive rates."

Medical Assurance has won national recognition for its leadership in providing malpractice protection to physicians, hospitals, dentists and healthcare organizations through risk financing and insurance programs that coordinate traditional insurance with effective clinical risk management.

For more information on Medical Assurance, please call **800-282-6242 or 877-4400** in Birmingham.

AMA and Intel credentials system to protect physician/patient communications on the Internet

The American Medical Association (AMA) has announced that it is working with Intel Corporation to deploy a new form of electronic credentials that will protect physician and patient privacy and confidentiality when they use the Internet to send and receive medical information. Digital credentials—which uniquely identify individuals over the Internet— will be issued to physicians early next year, providing a more reliable authentication technique than passwords for secure Internet transactions.

"The potential for the Internet to be used to obtain lab results, send prescriptions to pharmacies and receive patient files makes it vitally important that systems are in place to ensure that the patient's privacy and confidentiality are protected," said Richard Corlin, MD, Speaker of the House of Delegates of the AMA. "By authenticating the identity of the physician and ensuring the privacy of the patient, you enable a wide variety of routine medical transactions to occur online, benefiting busy physicians and enabling better patient care."

The decision to provide digital credentials is an outgrowth of the "Electronic Data Interchange Report" issued by the AMA Council on Medical Service in 1998. The Council recommended that the AMA work to establish consensus for electronic storage and transmission of medical records as an important means of protecting patient privacy. The Council also recommended that the AMA develop guidelines to develop educational tools or models in accordance with industry electronic security guidelines to assist physicians in compliance with state and federal regulations.

The AMA plans to offer digital credentials to physicians in early 2000. Testing of a prototype for physicians will begin later this month.

EDITOR, CON'T

not just that the information on the web is so broad and so voluminous; it's that some of this information has a different character from the definitive, stand-alone scientific facts with which we are familiar.

The best eyewitness to the history of the World Wide Web is its inventor, an Englishman named Tim Berners-Lee. His book, *Weaving the Web*, gives us a real inside view. This much of it I can understand: the central idea of the web is that everything is connected to everything else. There is no centralized database and thus there is neither control over what is on the web, nor any barrier to where you can go from anywhere else. The great benefit is that the business of making connections, from one key word or idea to the next, is seamless and instantaneous.

Another important principle of the web, and one dear to the heart of Berners-Lee, is that every file, every item of information, is equal to every other one on the web. There is no filtering and no weighting of the information. That leads us to why I think there is something qualitatively different to the information from the web, something subtle but important. The more one uses the web, the more one may lose track of the credibility of what one is reading. This is hardly a fatal flaw; we just need to get some perspective. But as a practical matter, how can we organize and manage websites so that we both save time and assure quality?

Enter Steven MacCall, Ph.D., and the Clinical Digital Library Project. In this issue, Dr. MacCall describes how librarians and computer scientists have begun to create their own web sites that physicians can use to manage the problems of quantity and quality when we access the Internet. For those of us who have wandered too often as nomads of cyberspace, what he offers is a welcome oasis of information in a desert of data.

This issue is devoted almost entirely to the computer and the medical Internet. H.C. "Moon" Mullins, MD gives his view of how "Medicine Meets Cyberspace." We also offer you a description of the pitfalls of telemedicine from the Mutual Assurance perspective; the initiatives of our talented MASA staff to make the best use of technology in our association's management; and an excellent discussion by FTC staff of health fraud schemes, in a form suitable for giving to our patients. Lest we become totally digitized, there are three excellent book reviews; one of which is Professor Edward Wilson's latest work, *The Unity of Knowledge*, a fitting analogic image for a digital world.

As for me, I plan to spend plenty of time on the Internet, including Professor MacCall's clinical digital library. Right now, though, I think I'll jump into *The Black Death.*★

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Ziegler, Philip. *The Black Death.* Alan Sutton Publishing Ltd., Dover, NH. 1969.

Berners-Lee, Tim. *Weaving the Web: The Original Design and Ultimate Destiny of the World Wide Web by Its Inventor.* HarperCollins, 1999. (http://www.harpercollins.com)

— William Curry, MD

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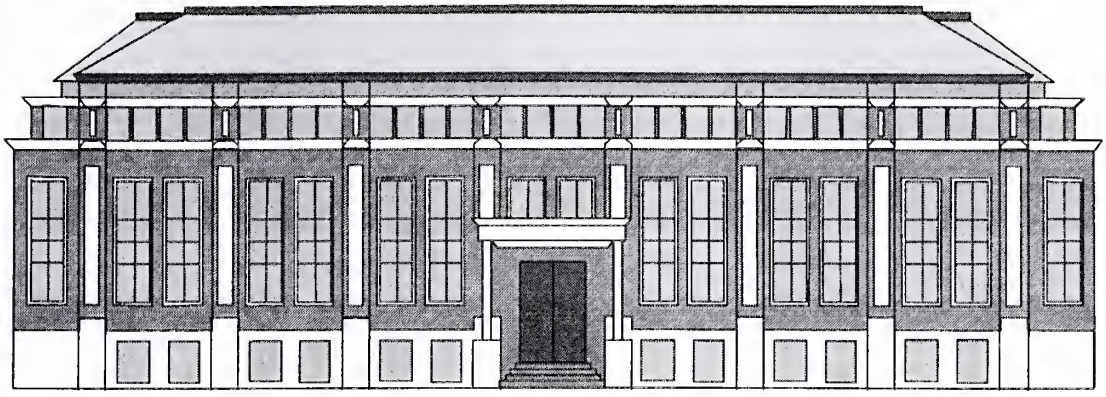

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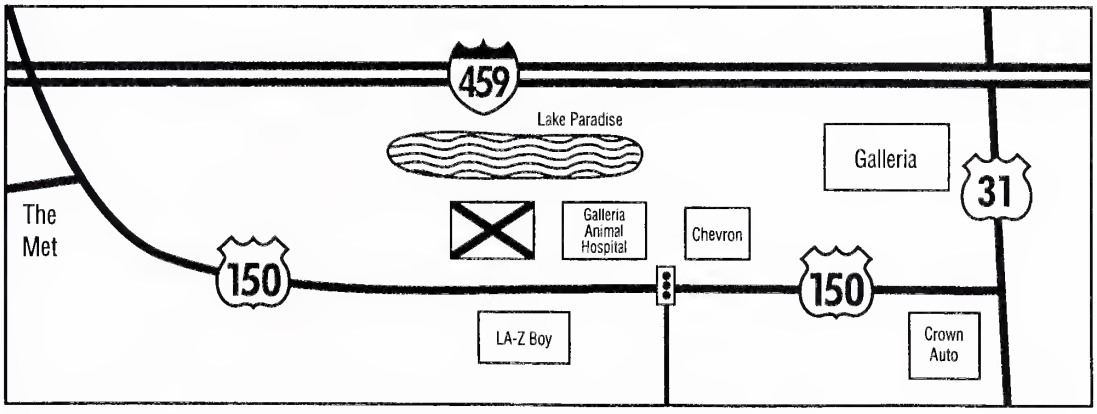

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